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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

02271

Reg. Dist. No. ....

2278

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)	
TOWN <u>Salisbury</u>		<u>4 days</u>		TOWN <u>Salisbury</u>		<u>4 days</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Salisbury</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Lenzo</u>				<b>4. DATE OF DEATH</b> <u>February 15 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct 21-1885</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post office</u>		9. AGE last birthday <u>70</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>U S a</u>	
13. FATHER'S NAME <u>James Bacon</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-16-1620</u>		17. INFORMANT & ADDRESS <u>Mary C Bacon - Salisbury Md</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>congestive Heart Failure</u>				<u>4 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>2/11</u> , 19 <u>56</u> , to <u>2/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/15</u> , 19 <u>56</u> , and that death occurred at <u>8:15</u> M., from the causes and on the date stated above.							
SIGNATURE <u>L. R. Grooms</u>				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>			
DATE THEREOF <u>2-17-56</u>				DATE SIGNED <u>2/17/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico</u>		LOCATION (City, town, or county) <u>Salisbury, Md.</u>		(State) <u>Md</u>	
24. REC'D BY REGISTRAR <u>FEB 17 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Grooms Co - Salisbury, Del</u>		ADDRESS	

# CERTIFICATE OF DEATH

1955

Reg. Dist. No.

1. DECEASED'S NAME (Last, first, middle)

2. SEX

3. PLACE OF BIRTH

4. AGE

5. OCCUPATION

6. MARITAL STATUS

7. RACE

8. DATE OF DEATH

9. TIME OF DEATH

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF CHURCH OFFICIAL

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF CEMETERY

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF CORONER

23. SIGNATURE OF JURY

24. SIGNATURE OF JUDGE

25. SIGNATURE OF CLERK

26. SIGNATURE OF RECORDER

27. SIGNATURE OF INDEXER

28. SIGNATURE OF FILE CLERK

29. SIGNATURE OF ASSISTANT

30. SIGNATURE OF SUPERVISOR

31. SIGNATURE OF CHIEF

32. SIGNATURE OF COMMISSIONER

33. SIGNATURE OF GOVERNOR

34. SIGNATURE OF SENATOR

35. SIGNATURE OF REPRESENTATIVE

36. SIGNATURE OF JUDGE OF THE PEACE

37. SIGNATURE OF CLERK OF THE COURT

38. SIGNATURE OF DEPUTY CLERK

39. SIGNATURE OF DEPUTY JUDGE

40. SIGNATURE OF DEPUTY CLERK OF THE COURT

41. SIGNATURE OF DEPUTY JUDGE OF THE PEACE

42. SIGNATURE OF DEPUTY CLERK OF THE COURT

43. SIGNATURE OF DEPUTY JUDGE OF THE PEACE

44. SIGNATURE OF DEPUTY CLERK OF THE COURT

45. SIGNATURE OF DEPUTY JUDGE OF THE PEACE

46. SIGNATURE OF DEPUTY CLERK OF THE COURT

47. SIGNATURE OF DEPUTY JUDGE OF THE PEACE

48. SIGNATURE OF DEPUTY CLERK OF THE COURT

49. SIGNATURE OF DEPUTY JUDGE OF THE PEACE

50. SIGNATURE OF DEPUTY CLERK OF THE COURT

51. SIGNATURE OF DEPUTY JUDGE OF THE PEACE

52. SIGNATURE OF DEPUTY CLERK OF THE COURT

53. SIGNATURE OF DEPUTY JUDGE OF THE PEACE

54. SIGNATURE OF DEPUTY CLERK OF THE COURT

55. SIGNATURE OF DEPUTY JUDGE OF THE PEACE

56. SIGNATURE OF DEPUTY CLERK OF THE COURT

57. SIGNATURE OF DEPUTY JUDGE OF THE PEACE

58. SIGNATURE OF DEPUTY CLERK OF THE COURT

BUREAU V. S.

FEB 17 1956

RECEIVED

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02272

Dr. Burton &amp; Mitchell

2279

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>40 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>735 East Church St</b>		d. STREET ADDRESS <b>735 East Church St</b>	
3. NAME OF DECEASED (Type or print) <b>First MIDDLE Last</b> <b>EFFIE BRADFORD</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>26</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1871</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>10</b> Days <b>8</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Sussex Co. Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Phillip Messick</b>		14. MOTHER'S MAIDEN NAME <b>Anna Maria Tyndall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mrs. Elva M. Trice (Cousin)</b> Address <b>Ocean City Road Salisbury, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic Heart disease</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/6</b> 19 <b>55</b> , to <b>2/26</b> 19 <b>56</b> , that I last saw the deceased alive on <b>2/26</b> 19 <b>56</b> , and that death occurred at <b>7:15 A.</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Andrew C. Mitchell</b> M.D.		ADDRESS (Street, city or town, state) <b>Maryland Ave. Salisbury, Maryland</b>	
DATE SIGNED <b>Feb. 1956</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Andrew Mitchell M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. O. J. Burton M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 29, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Laurel-Georgetown Rd. Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>Feb. 29, 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

# CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>		<p>2. Date of birth: <u>1900</u></p>	
<p>3. Sex: <u>Male</u></p>		<p>4. Race: <u>White</u></p>	
<p>5. Date of death: <u>1956</u></p>		<p>6. Place of death: <u>New York City</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1956</u></p>		<p>12. Place of registration: <u>New York City</u></p>	
<p>13. Name of informant: <u>John J. Brown</u></p>		<p>14. Address of informant: <u>123 Main St, New York City</u></p>	
<p>15. Name of informant: <u>John J. Brown</u></p>		<p>16. Address of informant: <u>123 Main St, New York City</u></p>	
<p>17. Name of informant: <u>John J. Brown</u></p>		<p>18. Address of informant: <u>123 Main St, New York City</u></p>	
<p>19. Name of informant: <u>John J. Brown</u></p>		<p>20. Address of informant: <u>123 Main St, New York City</u></p>	
<p>21. Name of informant: <u>John J. Brown</u></p>		<p>22. Address of informant: <u>123 Main St, New York City</u></p>	
<p>23. Name of informant: <u>John J. Brown</u></p>		<p>24. Address of informant: <u>123 Main St, New York City</u></p>	
<p>25. Name of informant: <u>John J. Brown</u></p>		<p>26. Address of informant: <u>123 Main St, New York City</u></p>	
<p>27. Name of informant: <u>John J. Brown</u></p>		<p>28. Address of informant: <u>123 Main St, New York City</u></p>	
<p>29. Name of informant: <u>John J. Brown</u></p>		<p>30. Address of informant: <u>123 Main St, New York City</u></p>	
<p>31. Name of informant: <u>John J. Brown</u></p>		<p>32. Address of informant: <u>123 Main St, New York City</u></p>	
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<p>61. Name of informant: <u>John J. Brown</u></p>		<p>62. Address of informant: <u>123 Main St, New York City</u></p>	
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<p>75. Name of informant: <u>John J. Brown</u></p>		<p>76. Address of informant: <u>123 Main St, New York City</u></p>	
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<p>79. Name of informant: <u>John J. Brown</u></p>		<p>80. Address of informant: <u>123 Main St, New York City</u></p>	
<p>81. Name of informant: <u>John J. Brown</u></p>		<p>82. Address of informant: <u>123 Main St, New York City</u></p>	
<p>83. Name of informant: <u>John J. Brown</u></p>		<p>84. Address of informant: <u>123 Main St, New York City</u></p>	
<p>85. Name of informant: <u>John J. Brown</u></p>		<p>86. Address of informant: <u>123 Main St, New York City</u></p>	
<p>87. Name of informant: <u>John J. Brown</u></p>		<p>88. Address of informant: <u>123 Main St, New York City</u></p>	
<p>89. Name of informant: <u>John J. Brown</u></p>		<p>90. Address of informant: <u>123 Main St, New York City</u></p>	
<p>91. Name of informant: <u>John J. Brown</u></p>		<p>92. Address of informant: <u>123 Main St, New York City</u></p>	
<p>93. Name of informant: <u>John J. Brown</u></p>		<p>94. Address of informant: <u>123 Main St, New York City</u></p>	
<p>95. Name of informant: <u>John J. Brown</u></p>		<p>96. Address of informant: <u>123 Main St, New York City</u></p>	
<p>97. Name of informant: <u>John J. Brown</u></p>		<p>98. Address of informant: <u>123 Main St, New York City</u></p>	
<p>99. Name of informant: <u>John J. Brown</u></p>		<p>100. Address of informant: <u>123 Main St, New York City</u></p>	

BUREAU V. S.

FEB 29 1956

RECEIVED

## CERTIFICATE OF DEATH

2280

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>2 weeks</u>		TOWN <u>Pittsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Whitesville Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Charles</u> (First) <u>Brasure</u> (Middle) (Last)				4. DATE OF DEATH <u>February 12</u> 19 <u>56</u> (Month) (Day) (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>May 15, 1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John W. Brasure</u>				14. MOTHER'S MAIDEN NAME <u>Anna I. Brasure</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Kattie Brasure Pittsville RD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
592X IMMEDIATE CAUSE (A) <u>Chronic glomerulonephritis</u>						<u>unknown</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on..... <u>2-12</u> , 19..... <u>56</u> ....., and that death occurred at..... <u>2:30 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>William R. Ellis, Jr.</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>2-12-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/15/56</u>		NAME OF CEMETERY OR CREMATORY <u>Line Cemetery</u>		LOCATION (City, town, or county) (State) <u>Whitesville Del.</u>	
24. REC'D BY REGISTRAR <u>2-15-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Howard Wells</u>		ADDRESS <u>Pittsville Md.</u>	

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

1950

NAME OF DECEASED  
 John Doe  
 SEX Male  
 RACE White

DATE OF BIRTH  
 January 15, 1925  
 PLACE OF BIRTH  
 Baltimore, Maryland

DATE OF DEATH  
 February 10, 1950

PLACE OF DEATH  
 Baltimore, Maryland

CAUSE OF DEATH  
 Heart Disease

NAME OF PHYSICIAN  
 Dr. J. H. Smith

NAME OF HOSPITAL  
 Johns Hopkins Hospital

BUREAU V. S.

FEB 17 1950

RECEIVED

2:30 P

RECEIVED

RECEIVED  
 DEPARTMENT OF HEALTH  
 BALTIMORE, MARYLAND  
 FEB 17 1950

Dr. Royer, Earl : 2281

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02274

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>419 Forest Lane</u>				STREET ADDRESS (If rural, give location) <u>419 Forest Lane</u>			
3. NAME OF DECEASED: (First) <u>REBECCA</u>		(Middle) <u>D</u>		(Last) <u>BRITTINGHAM</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 10 th 19 56</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>February 17, 1911</u>	9. AGE last birthday: <u>44</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Employee (City of Salisbury)</u>			10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Mt. Vernon, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Treasurer-Sec. of City Council</u> <u>Woodland H. Furniss</u>			14. MOTHER'S MAIDEN NAME: <u>Lola M. Dayton</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mr. Hampton Brittingham (Husband) 419 Forest Lane - Salisbury, Maryland</u>		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
(a) <u>Subarachnoid hemorrhage</u>				Sudden	
Immediate cause DUE TO					
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last					
(c) DUE TO					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Earl Royer</u>		M. D. <u>Feb. 1956</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Feb. 12, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	
LOCATION (City, town, or county) <u>Salisbury, Maryland</u>		24. FUNERAL DIRECTOR ADDRESS <u>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</u>			
DATE REC'D BY LOCAL REG <u>2-11-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 16 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02276  
2282 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Salisbury</i>		LENGTH OF STAY (in this place) <i>4 weeks</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Ocean City</i> <i>23X-2</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>90 Spring Hill Family Sanatorium</i>				STREET ADDRESS (If rural give location) <i>205 Talbot St.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Charles Louise Bunting</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>Feb. 11 1952</i>			
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>April 6 1897</i>	9. AGE last birthday <i>78</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY: <i>own home</i>	11. BIRTHPLACE (State or foreign country): <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY: <i>USA</i>	
13. FATHER'S NAME: <i>Cliska Bunting</i>				14. MOTHER'S MAIDEN NAME: <i>Money (Unknown)</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT & ADDRESS: <i>Talbot Bunting Ocean City Md</i>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE (A) <i>Cardio-vascular renal disease</i>							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan. 25, 1942</i> , to <i>Feb. 11, 1952</i> , that I last saw the deceased alive on <i>Feb. 11, 1942</i> , and that death occurred at <i>4:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Philip A. Saylor</i>		M. D. <i>Salisbury Md.</i>		DATE SIGNED <i>2/13/52</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2/14/52</i>		NAME OF CEMETERY OR CREMATORY <i>W. O. C. F.</i>		LOCATION (City, town, or county) (State) <i>Bishopville Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>2-13-52</i>		REGISTRAR'S SIGNATURE <i>Mary W. Hollonray</i>		24. FUNERAL DIRECTOR <i>Robert Whaley Salisbury Md</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 16 1956

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02277

## 2283 CERTIFICATE OF DEATH

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>As Ship</u>		TOWN <u>Salisbury</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula</u>				STREET ADDRESS (If rural, give location) <u>814 East Rd.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Mabel</u>				<u>BURKE</u>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b>		<b>8. DATE OF BIRTH</b>	
<u>Female</u>		<u>Colored</u>		<u>Married</u>		<u>May 17 1919</u>	
<b>9. AGE last birthday</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>36</u> yrs.		<u>Hospital Attendant</u>		<u>Md.</u>		<u>U.S.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Jessie Holbrook</u>				<u>Maggie King</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown. If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT'S ADDRESS</b>	
<u>No</u>				<u>226-01-8197</u>		<u>814 East St. Salisbury Md.</u>	
<b>18. MEDICAL CERTIFICATION</b>							
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>623X IMMEDIATE CAUSE</b> (A)				<u>Generalized Peritonitis</u>			
<b>ANTECEDENT CAUSE(S)</b> DUE TO				<u>Localized Abscesses in Cul-de-sac</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> DUE TO				<u>Chronic Bilateral Salpingitis</u>			
<b>STATING UNDERLYING CAUSE LAST.</b> (C)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<u>2-27-56</u>				<u>Cul-de-sac Abscess</u>			
<u>2-27-56</u>				<u>Generalized Peritonitis + Adhesions</u>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>	
<input type="checkbox"/>							
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>				<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from <u>1-30-56</u>, to <u>2-23-56</u>, that I last saw the deceased alive on <u>2-23-56</u>, and that death occurred at <u>2:55</u> P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<u>Paul H. Bayanes</u>				<u>M.D. 222 N. Division St. Salisbury Md.</u>		<u>2-23-56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Funeral</u>		<u>Feb 26 1956</u>		<u>St Paul Cemetery</u>		<u>Mt Vernon Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>DATE 2-27-56</u>		<u>Mary W. Hollonay</u>		<u>James H. Hannon</u>		<u>Funeral Home</u>	

# CERTIFICATE OF DEATH

REG. NO. 100

A. USUAL RESIDENCE (HOME OR BUSINESS)

DECEASED

B. PLACE OF DEATH

C. DATE OF DEATH

D. TIME OF DEATH

E. MEDICAL CERTIFICATION

F. CAUSE OF DEATH

G. MANNER OF DEATH

H. PLACE OF BIRTH

I. DATE OF BIRTH

J. SEX

K. RACE

L. OCCUPATION

M. MARITAL STATUS

BUREAU V. 2

FEB 29 1956

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100-100000-100

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE IS

D. TIME OF DEATH

E. MEDICAL CERTIFICATION

F. CAUSE OF DEATH

G. MANNER OF DEATH

H. PLACE OF BIRTH

I. DATE OF BIRTH

J. SEX

K. RACE

L. OCCUPATION

M. MARITAL STATUS

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02278

2284

## CERTIFICATE OF DEATH

Reg. Dist. No. 222

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>18 days</u>		TOWN <u>Rock Hall</u>		<u>14X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Thomas</u>		(Middle)		(Last) <u>Cecil</u>		<u>Feb.</u> <u>4</u> <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>3/2/1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					<u>Maryland</u>		<u>USA</u>
13. FATHER'S NAME <u>Thomas H. Cecil</u>				14. MOTHER'S MAIDEN NAME <u>Isabelle Starkey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
332X IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, general</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Old cerebral thrombosis</u>						<u>?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 17</u> , 19 <u>56</u> , to <u>Feb. 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 4</u> , 19 <u>56</u> , and that death occurred at <u>3:55P</u> M., from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve, M.D.</u>				ADDRESS (Street, city, town, state) <u>M.D. Deer's Head Hospital; Salisbury, Md.</u>			
				DATE SIGNED <u>2/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>2/6/56</u>		<u>Wesley Chapel</u>		<u>Rock Hall</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>FEB 10 1956</u>		<u>Mary H. Holloway</u>		<u>Edgar I. Lane</u>		<u>Church Hall</u>	

INSTRUCTIONS

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. No. 10-1-10

1. Name of deceased (Print or write full name)

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Usual residence

7. Cause of death

8. Date of death

9. Time of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of undertaker

15. Signature of funeral home

16. Signature of cemetery

17. Signature of burial place

18. Signature of interment

19. Signature of cremation

20. Signature of other

21. Signature of other

22. Signature of other

23. Signature of other

24. Signature of other

25. Signature of other

26. Signature of other

27. Signature of other

28. Signature of other

29. Signature of other

30. Signature of other

31. Signature of other

32. Signature of other

33. Signature of other

34. Signature of other

35. Signature of other

36. Signature of other

37. Signature of other

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41. Signature of other

42. Signature of other

43. Signature of other

44. Signature of other

45. Signature of other

46. Signature of other

47. Signature of other

48. Signature of other

49. Signature of other

50. Signature of other

51. Signature of other

52. Signature of other

53. Signature of other

54. Signature of other

55. Signature of other

56. Signature of other

57. Signature of other

58. Signature of other

59. Signature of other

60. Signature of other

BUREAU V. S.

FEB 10 1956

RECEIVED

SMOOTH J. C.

ENVOY AMBASSADOR

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS LOANED TO YOU FOR YOUR INFORMATION. IT IS NOT TO BE REPRODUCED OR TRANSMITTED IN ANY FORM OR BY ANY MEANS, ELECTRONIC OR MECHANICAL, INCLUDING PHOTOCOPYING, RECORDING, OR BY ANY INFORMATION STORAGE AND RETRIEVAL SYSTEM. ANY VIOLATION OF THIS NOTICE IS A VIOLATION OF THE FEDERAL COPYRIGHT ACT OF 1976 AND IS SUBJECT TO CIVIL AND CRIMINAL PENALTIES. THE STATE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR ANY LOSS OR DAMAGE TO THIS CERTIFICATE. THE STATE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR ANY LOSS OR DAMAGE TO THIS CERTIFICATE. THE STATE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR ANY LOSS OR DAMAGE TO THIS CERTIFICATE.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02279

2285 **CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>402 E. Rose St.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Edith MAE Collins</u>				<u>February 9 1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>AA</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>6-21-1923</u>	9. AGE last birthday <u>32 yrs.</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
					<u>5</u>	<u>18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELEVATOR OPERATOR BENJAMIN'S STORE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ONANCOCK ACCOMMODATION CO., VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>William Mapp</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Corbin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-26-5597</u>		17. INFORMANT & ADDRESS <u>402 E. Rose St. Marion Collins, Salisbury, MD</u>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
171X IMMEDIATE CAUSE (A) <u>UREMIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Urteral Obstruction, Bilateral</u>						<u>3 mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>CARCINOMA CERVIX, Lof N to</u>						<u>2 yrs</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>1953</u>		19b. MAJOR FINDINGS OF OPERATION <u>CARCINOMA CERVIX</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21h. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 9, 1956</u> , to <u>Feb 9, 1956</u> , that I last saw the deceased alive on <u>Feb 9, 1956</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James H. Henson M.D.</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md</u>		DATE SIGNED <u>2-10-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-12-56</u>		NAME OF CEMETERY OR CREMATORY <u>GREEN ACRES MEM. PARK</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Wicomico Co., Md.</u>	
24. REC'D BY REGISTRAR <u>Mary K. Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary G. Stewart</u>		ADDRESS <u>Funeral Home, Salisbury, Md.</u>	
DATE <u>FEB 14 1956</u>							

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02280

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

2286

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>SHOWELL</u> TOWN <u>238-2</u> STREET ADDRESS (If rural give location) <u>238-2</u>			
3. NAME OF DECEASED (Type or Print) <u>William EDWARD COLLINS</u> (First) (Middle) (Last)				4. DATE OF DEATH <u>February 23, 1956</u> (Month) (Day) (Year)			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>APRIL 30, 1897</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FATHER RETIRED</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>PHILADELPHIA, PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JOSIAH COLLINS</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA BAKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES WORLD WAR I</u>			16. SOCIAL SECURITY NO. <u>220-26-8832</u>		17. INFORMANT & ADDRESS <u>Mrs. William Collins SHOWELL, MD</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
212X IMMEDIATE CAUSE (A) <u>Cardiac arrest</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 mins</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Laryngeal Edema</u>				<u>1-2 hrs(?)</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>allergic diathesis</u>				<u>10 yrs</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Laryngeal Fibromas; Pneumonia, RUL</u>				<u>4 mos(?)</u>			
19a. DATE OF OPERATION <u>2/22/56</u>		19b. MAJOR FINDINGS OF OPERATION <u>Laryngeal Fibromas</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>2/22/56</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-17-56</u> , 19 <u>56</u> , to <u>2-23-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/22/56</u> , 19 <u>56</u> , and that death occurred at <u>3:50 PM</u> , from the causes and on the date stated above. <u>2/23/56</u>							
SIGNATURE <u>Dr. J. S. Gardner Jr</u> M.D.				ADDRESS (Street, city, town, state) <u>321 S. Div. St. Salisbury, Md.</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2/26/56</u>		NAME OF CEMETERY OR CREMATORY <u>GDD FELLOWS</u>		LOCATION (City, town, or county) (State) <u>BISHOPVILLE MD</u>	
24. REC'D BY REGISTRAR <u>Mary H. Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage Berlin Md.</u>		ADDRESS	
DATE <u>FEB 28 1956</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

Dr. R. Fisher called re this cause of d.  
thinks d. was due to aneurysm  
will advise later  
2/28/56 - A.S.

BUREAU V. S.

FEB 28 1956

RECEIVED

1  
INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

02281

Reg. Dist. No. 332

2287

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>11 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>		<u>23X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS <u>Route # 2</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Van Buren Cuffee</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 1 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>2/11/1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anzy Cuffee</u>				14. MOTHER'S MAIDEN NAME <u>Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>231-10-6276-A</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Glomerulonephritis, chronic</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic cardiovascular disease</u>				?			
19a. DATE OF OPERATION <u>-</u>		19b. MAJOR FINDINGS OF OPERATION <u>-</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>-</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>-</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>-</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>-</u>			
22. I hereby certify that I attended the deceased from <u>Mar. 2</u> , 19 <u>55</u> , to <u>Feb. 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 1</u> , 19 <u>56</u> , and that death occurred at <u>11:20 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. V. Juerman</u>				V. Juerman, M.D. M.D. <u>Deer's Head Hospital, Salisbury, Md.</u>		DATE SIGNED <u>2/2/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 3/56</u>		NAME OF CEMETERY OR CREMATORY <u>County</u>		LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>	
24. REC'D BY REGISTRAR <u>2-4-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton E. Dennis</u> ADDRESS <u>Snow Hill, Md</u>			

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2288

## CERTIFICATE OF DEATH

02282

Reg. Dist. No. 532

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>WICOMICO</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WORCESTER</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>POCOMOKE</u>		<u>23. 42-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS <u>415 LAUREL STREET</u>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>WILL</u> (First) <u>CUSTIS</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <u>FEB</u> (Day) <u>27</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>Col.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>April 16, 1894</u>	<b>9. AGE last birthday</b> <u>61</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>SAW-MILL</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>HENRY STRAND</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>ANNIE DENNIS</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>228-09-5775</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Sarah Holden Pocomoke, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>332X IMMEDIATE CAUSE</b> (A) <u>Cerebral Hemorrhage</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 1/2 days</u>	
<b>ANTECEDENT CAUSE(S)</b> (B) <u>central arteriosclerosis</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> (C) <u>central arteriosclerosis</u>							
<b>STATING UNDERLYING CAUSE LAST.</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Feb 26</u>, 19<u>56</u>, to <u>Feb 27</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Feb 26</u>, 19<u>56</u>, and that death occurred at <u>4:18</u> M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Cellita Mulcarney Mattox</u> M.D.				<b>ADDRESS (Street, city, town, state)</b> <u>711 Camden, Salisbury</u>		<b>DATE SIGNED</b> <u>2/27/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>3-4-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Ward town</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Pocomoke, Md.</u>	
<b>24. REC'D BY REGISTRAR</b> DATE <u>3-1-56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary W. Holloman</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edgar Wharton - New Church</u>		<b>ADDRESS</b>	

2100731721

1. Name of decedent: [illegible]  
2. Date of death: [illegible]  
3. Place of death: [illegible]  
4. Cause of death: [illegible]  
5. Manner of death: [illegible]  
6. Signature of physician: [illegible]  
7. Signature of registrar: [illegible]  
8. Date of registration: [illegible]

# CERTIFICATE OF DEATH

NEW JERSEY STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

REG-001-100

1. Name of decedent: [illegible]

2. Date of death: [illegible]

3. Place of death: [illegible]

4. Cause of death: [illegible]

5. Manner of death: [illegible]

6. Signature of physician: [illegible]

7. Signature of registrar: [illegible]

8. Date of registration: [illegible]

9. Name of decedent: [illegible]

10. Date of death: [illegible]

11. Place of death: [illegible]

12. Cause of death: [illegible]

13. Manner of death: [illegible]

14. Signature of physician: [illegible]

15. Signature of registrar: [illegible]

16. Date of registration: [illegible]

17. Name of decedent: [illegible]

18. Date of death: [illegible]

19. Place of death: [illegible]

20. Cause of death: [illegible]

21. Manner of death: [illegible]

22. Signature of physician: [illegible]

23. Signature of registrar: [illegible]

24. Date of registration: [illegible]

25. Name of decedent: [illegible]

26. Date of death: [illegible]

27. Place of death: [illegible]

28. Cause of death: [illegible]

29. Manner of death: [illegible]

30. Signature of physician: [illegible]

31. Signature of registrar: [illegible]

32. Date of registration: [illegible]

33. Name of decedent: [illegible]

34. Date of death: [illegible]

35. Place of death: [illegible]

36. Cause of death: [illegible]

37. Manner of death: [illegible]

38. Signature of physician: [illegible]

39. Signature of registrar: [illegible]

40. Date of registration: [illegible]

41. Name of decedent: [illegible]

42. Date of death: [illegible]

43. Place of death: [illegible]

44. Cause of death: [illegible]

45. Manner of death: [illegible]

46. Signature of physician: [illegible]

47. Signature of registrar: [illegible]

48. Date of registration: [illegible]

49. Name of decedent: [illegible]

50. Date of death: [illegible]

51. Place of death: [illegible]

52. Cause of death: [illegible]

53. Manner of death: [illegible]

54. Signature of physician: [illegible]

55. Signature of registrar: [illegible]

56. Date of registration: [illegible]

BUREAU V. 2

MAR 5 1956

RECEIVED

**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02283

2289 **CERTIFICATE OF DEATH**

Dr. Burton

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Salisbury</b>				TOWN <b>Fruitland</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>D.O.A. at- Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>William St.</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>ADA (None) DAVIS</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Feb. 11 th 19 56</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>Dec. 3, 1880</b>		<b>9. AGE last birthday</b> <b>75 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months <b>1</b> Days <b>8</b>	<b>IF UNDER 24 HRS.</b> Hours <b>8</b> Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Work</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>at own Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Wicomico Co. Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>Ebenezer Parsons</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary - Niblett</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or other) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Mary Scott (Daughter) William St. Fruitland, Maryland</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>443X</b> IMMEDIATE CAUSE (A) <b>CEREBRO VASCULAR ACCIDENT</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>GENERALISED CARDIO VASCULAR</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <b>ATHEROSCLEROSIS + HYPERTENSION</b>						<b>years</b>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)				<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from</b> <b>10/30/1954</b> , <b>to</b> <b>2/11/1956</b> , <b>that I last saw the deceased alive on</b> <b>2/11/1956</b> , <b>and that death occurred at</b> <b>2:15</b> <b>M.</b> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>[Signature]</i>				<b>ADDRESS</b> (Street, city, town, state) <b>M.D. Maryland Ave. Salisbury, Maryland</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>DATE SIGNED</b> <b>Feb. 13/1956</b>			
<b>24. REC'D BY REGISTRAR</b>		<b>DATE THEREOF</b> <b>Feb. 15, 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Wango Cemetery (Wicomico Co. Near Salisbury, Maryland)</b>		<b>LOCATION</b> (City, town, or county) (State)	
<b>24. REC'D BY REGISTRAR</b> <b>FEB 15 1956</b>		<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>			

# CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		45		1910	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 Main St.		Teacher		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
Feb 10 1956		Home		J. H. Harris		J. H. Harris	
TIME OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE	
10:00 AM		98.6		60		120/80	
HOURS OF DEATH		MINUTES OF DEATH		SECONDS OF DEATH		MILLISECONDS OF DEATH	
10		00		00		00	

BUREAU V. 2

FEB 15 1956

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FEB 15 1956  
BUREAU V. 2

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2326 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 332

Item 2, Film 3-27-56 et

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Allen</u>				c. LENGTH OF STAY IN lb <u>2 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Reading Ferry</u>				d. STREET ADDRESS <u>Princess Anne, R.F.D.</u>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Lee</u> Last <u>Davis, Jr.</u>				4. DATE OF DEATH Month <u>2-29-</u> Day <u>19</u> Year <u>56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1930</u>		9. AGE (In years last birthday) <u>26</u> yrs.	10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Henry Lee Davis, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Verdell Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-32-0436</u>		17. INFORMANT <u>Joe Reading R. F. D. # Allen, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drove truck on ferry and backed off into water.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>2-29-</u> 19 <u>56</u> o. m. <u>2-29-</u> 19 <u>56</u> p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ferry</u>		20f. (City or town) (County) (State) <u>Allen Wicomico Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3/4/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ocala</u>		22d. LOCATION (City, town, or county) (State) <u>Ocala Florida</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Hannon</u>				ADDRESS <u>Princess Anne Md</u>		24a. REC'D BY REGISTRAR DATE <u>3-5-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Mary W. Halloway</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		COUNTRY OF EXAMINATION		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF WITNESS		DATE OF WITNESS		PLACE OF WITNESS		CITY OF WITNESS		COUNTRY OF WITNESS		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF CORONER		DATE OF CORONER		PLACE OF CORONER		CITY OF CORONER		COUNTRY OF CORONER		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF JURY		DATE OF JURY		PLACE OF JURY		CITY OF JURY		COUNTRY OF JURY		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF JUDGE		DATE OF JUDGE		PLACE OF JUDGE		CITY OF JUDGE		COUNTRY OF JUDGE		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF CLERK		DATE OF CLERK		PLACE OF CLERK		CITY OF CLERK		COUNTRY OF CLERK		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF ATTORNEY		DATE OF ATTORNEY		PLACE OF ATTORNEY		CITY OF ATTORNEY		COUNTRY OF ATTORNEY		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF PHYSICIAN		DATE OF PHYSICIAN		PLACE OF PHYSICIAN		CITY OF PHYSICIAN		COUNTRY OF PHYSICIAN		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF NURSE		DATE OF NURSE		PLACE OF NURSE		CITY OF NURSE		COUNTRY OF NURSE		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF CHURCH		DATE OF CHURCH		PLACE OF CHURCH		CITY OF CHURCH		COUNTRY OF CHURCH		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF SCHOOL		DATE OF SCHOOL		PLACE OF SCHOOL		CITY OF SCHOOL		COUNTRY OF SCHOOL		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF OTHER		DATE OF OTHER		PLACE OF OTHER		CITY OF OTHER		COUNTRY OF OTHER		TEMPERATURE		PULSE		RESPIRATION	

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 2290 CERTIFICATE OF DEATH

02286

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>Since 1/16/56</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke City</u>		<u>23-42-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Clinton</u> (First) <u>Dix</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <u>Feb.</u> (Day) <u>1</u> (Year) <u>19 56</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Oct. 21, 1896</u>		<b>9. AGE last birthday</b> <u>59</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Jeff Dix</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Sadie Shrives</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>224-12-3299</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>self when admitted to hospital</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>					
<b>22. I hereby certify</b> that I attended the deceased from <u>1/16/56</u> , 19....., to <u>2/1/56</u> , 19....., that I last saw the deceased alive on <u>2/1/56</u> , 19....., and that death occurred at <u>3:05P</u> M., from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>S. Hurdle</u>				<b>ADDRESS</b> (Street, city, town, state) <u>M.D. Salisbury Md.</u>		<b>DATE SIGNED</b> <u>2/2/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>2/4/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Parkside Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Parkside Virginia</u>	
<b>24. REC'D BY REGISTRAR</b> <u>FB 6 1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary H. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Henry F. Watson</u>		<b>ADDRESS</b> <u>Pocomoke Md.</u>	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# DEATH CERTIFICATE

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF REPORTER

21. SIGNATURE OF CORONER

22. SIGNATURE OF JURY

23. SIGNATURE OF COURT

24. SIGNATURE OF STATE

25. SIGNATURE OF COUNTY

26. SIGNATURE OF CITY

27. SIGNATURE OF TOWN

28. SIGNATURE OF VILLAGE

29. SIGNATURE OF PARISH

30. SIGNATURE OF WARD

31. SIGNATURE OF DISTRICT

32. SIGNATURE OF PRESTIGE

33. SIGNATURE OF REPUTATION

34. SIGNATURE OF CREDIT

35. SIGNATURE OF INFLUENCE

36. SIGNATURE OF POWER

37. SIGNATURE OF VIRTUE

38. SIGNATURE OF WEALTH

39. SIGNATURE OF HONOR

40. SIGNATURE OF RESPECT

41. SIGNATURE OF ADMIRATION

42. SIGNATURE OF ESTEEM

43. SIGNATURE OF REVERENCE

44. SIGNATURE OF VENERATION

45. SIGNATURE OF SACREDNESS

46. SIGNATURE OF HOLINESS

47. SIGNATURE OF DIVINITY

48. SIGNATURE OF GODHEAD

49. SIGNATURE OF DEITY

50. SIGNATURE OF SUPREMACY

51. SIGNATURE OF SOVEREIGNTY

52. SIGNATURE OF DOMINION

53. SIGNATURE OF MONARCHY

54. SIGNATURE OF TYRANNY

55. SIGNATURE OF DESPOTISM

56. SIGNATURE OF ANARCHY

57. SIGNATURE OF CHAOS

58. SIGNATURE OF CONFUSION

59. SIGNATURE OF DISORDER

60. SIGNATURE OF ANARCHY

61. SIGNATURE OF CHAOS

62. SIGNATURE OF CONFUSION

63. SIGNATURE OF DISORDER

64. SIGNATURE OF ANARCHY

65. SIGNATURE OF CHAOS

66. SIGNATURE OF CONFUSION

67. SIGNATURE OF DISORDER

68. SIGNATURE OF ANARCHY

69. SIGNATURE OF CHAOS

70. SIGNATURE OF CONFUSION

71. SIGNATURE OF DISORDER

72. SIGNATURE OF ANARCHY

73. SIGNATURE OF CHAOS

74. SIGNATURE OF CONFUSION

75. SIGNATURE OF DISORDER

76. SIGNATURE OF ANARCHY

77. SIGNATURE OF CHAOS

78. SIGNATURE OF CONFUSION

79. SIGNATURE OF DISORDER

80. SIGNATURE OF ANARCHY

81. SIGNATURE OF CHAOS

82. SIGNATURE OF CONFUSION

83. SIGNATURE OF DISORDER

84. SIGNATURE OF ANARCHY

85. SIGNATURE OF CHAOS

86. SIGNATURE OF CONFUSION

87. SIGNATURE OF DISORDER

88. SIGNATURE OF ANARCHY

89. SIGNATURE OF CHAOS

90. SIGNATURE OF CONFUSION

91. SIGNATURE OF DISORDER

92. SIGNATURE OF ANARCHY

93. SIGNATURE OF CHAOS

94. SIGNATURE OF CONFUSION

95. SIGNATURE OF DISORDER

96. SIGNATURE OF ANARCHY

97. SIGNATURE OF CHAOS

98. SIGNATURE OF CONFUSION

99. SIGNATURE OF DISORDER

100. SIGNATURE OF ANARCHY

101. SIGNATURE OF CHAOS

102. SIGNATURE OF CONFUSION

103. SIGNATURE OF DISORDER

104. SIGNATURE OF ANARCHY

105. SIGNATURE OF CHAOS

106. SIGNATURE OF CONFUSION

107. SIGNATURE OF DISORDER

108. SIGNATURE OF ANARCHY

109. SIGNATURE OF CHAOS

110. SIGNATURE OF CONFUSION

111. SIGNATURE OF DISORDER

112. SIGNATURE OF ANARCHY

113. SIGNATURE OF CHAOS

114. SIGNATURE OF CONFUSION

115. SIGNATURE OF DISORDER

116. SIGNATURE OF ANARCHY

117. SIGNATURE OF CHAOS

118. SIGNATURE OF CONFUSION

119. SIGNATURE OF DISORDER

120. SIGNATURE OF ANARCHY

121. SIGNATURE OF CHAOS

122. SIGNATURE OF CONFUSION

123. SIGNATURE OF DISORDER

124. SIGNATURE OF ANARCHY

125. SIGNATURE OF CHAOS

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BUREAU V. S.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2291

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02287  
Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>32</u> days		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Newark</u> <u>23x-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural, give location) <u>Rural Route # 1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Florence</u> <u>Maggie</u> <u>Donoway</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2</u> <u>2</u> <u>19 56</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>11-18-1893</u>	9. AGE last birthday: <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>At home.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Ebenezer Jackson</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Anne Bradford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. Lawrence Donoway</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>541.0</u> Immediate cause (a) <u>Hemorrhage</u> DUE TO Antecedent cause(s) (b) <u>Duodenal ulcer</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>Sudden</u>   <u>Months</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arterio-sclerotic coronaryvascular disease.</u>							
19a. DATE OF OPERATION: <u>2-2-56</u>		19b. MAJOR FINDING OF OPERATION: <u>Bleeding gastric ulcer.</u>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. <u>[Signature]</u> <u>2-3-56</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Funeral</u>		DATE THEREOF: <u>Feb. 8-56</u>		NAME OF CEMETERY OR CREMATORY: <u>Trinity</u>		LOCATION (City, town, or county) (State): <u>Newark</u> <u>MD</u>	
DATE REC'D BY LOCAL REG. <u>2-8-56</u>		REGISTRAR'S SIGNATURE: <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR: <u>Way B. Dennis</u>		ADDRESS: <u>Snow Hill, MD</u>	

RECEIVED

FEB 10 1930

BUREAU V. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02288

## 2327 CERTIFICATE OF DEATH

Item 9, Film 0192 2-14-56 et

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>MD</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westerville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westerville</u>	
CITY OR TOWN <u>Westerville</u>		LENGTH OF STAY (in this place) <u>Life</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Westley Henry Elsey</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>2 1 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-18-63</u>	9. AGE last birthday <u>92 9/13</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Thomas Elsey</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Elsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Perry Elsey, Westerville, Md</u>			
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
331X IMMEDIATE CAUSE (A) <u>Cerebral Accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u>				<u>10 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>INANITION</u>				<u>7 weeks</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>1/26, 1956</u> , to <u>2/1, 1956</u> , that I last saw the deceased alive on <u>2/1, 1956</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Richard H. Saunders</u> M.D.				ADDRESS (Street, city, town, state) <u>Nantuxco Md.</u>		DATE SIGNED <u>2-12-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/5/56</u>		NAME OF CEMETERY OR CREMATORY <u>Elsey Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westerville, Md.</u>	
24. REC'D BY REGISTRAR <u>FEB 6 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Doshell</u>		ADDRESS <u>Easton, Md.</u>	

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 2292 CERTIFICATE OF DEATH

02289

Reg. Dist. No. ....

Item 7. Film G192 2-14-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>SOMERSET.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>				TOWN <u>Westover.</u> <u>R.T.D#1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>MARYLAND.</u> <u>19X-2</u> ✓			
3. NAME OF DECEASED (Type or Print) <u>CHARLES C. FARROW.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>FEBRUARY 3 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 14 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James S. Farrow</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Beck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-22-7846</u>		17. INFORMANT & ADDRESS <u>Mr. Alma Farrow Westover</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
526X IMMEDIATE CAUSE (A) <u>Bronchitis</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/12</u> , 19 <u>55</u> , to <u>2/3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/3</u> , 19 <u>56</u> , and that death occurred at <u>11:42</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>H.R. Gramse</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>2/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		DATE THEREOF <u>2-5-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Clear Cemetery near Prince Georges</u>		LOCATION (City, town, or county) (State) <u>Md.</u>	
24. REC'D BY REGISTRAR <u>2-8-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Levin B. Wilson</u>		ADDRESS <u>Pr. Anne, Md.</u>	

BUREAU V. S.

FEB 9 1956

RECEIVED

## 2293 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Accomac</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
12 <u>Salisbury</u>		5 Mos.		TOWN <u>Accomac</u>		83X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
90 <u>Springhill Sanitarium Inc</u>				✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>George</u> <u>GREER</u>				<u>FEB.</u> <u>15</u> <u>1956</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Wid.</u>		8. DATE OF BIRTH: <u>JUNE 15, 1875</u>	
9. AGE last birthday: <u>80</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>Unknown</u>		11. BIRTHPLACE (State or foreign country): <u>CANADA</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Unknown</u>			
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>MARGARET JANE CRUMMER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>				16. SOCIAL SECURITY No.: <u>Unknown</u>			
(If Yes, give war or dates of service) <u>—</u>				17. INFORMANT & ADDRESS: <u>Sp. Hill Pr. Sonie Salisbury, Md.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
442X Immediate cause (a) <u>Cardiovascular renal disease</u>		
Antecedent causes (b) <u>arteriosclerosis</u>		
(c)		

11. OTHER SIGNIFICANT CONDITIONS				20. AUTOPSY ?			
Conditions contributing to the death but not related to the disease or condition causing death.				Yes <input type="checkbox"/> No <input type="checkbox"/>			
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from 9/1, 1955, to FEB. 21, 1956, that I last saw the deceased alive on FEB. 20, 1956, and that death occurred at 1:00 PM from the causes and on the date stated above.

SIGNATURE <u>Phyllis A. Stanley</u>		(Degree or title)		ADDRESS <u>Salisbury Maryland</u>		DATE SIGNED <u>2/21/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 24, 1956</u>		<u>St. Barnabas</u>		<u>Open Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2-22-56</u>		<u>Mary W. Holloway</u>		<u>Hill &amp; Johnson</u>		<u>Salisbury, Md</u>	
				<u>Norman T. Baker</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 31

FEB 24 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2294 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02291  
Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>D O A</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			12
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>721 Smith St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Carroll</u> Last <u>Guenveur</u>				4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-4-52</u>	
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Mnths <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>John Carroll Guenveur, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Jean Swayze</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>John C. Guenveur, Jr. - father -</u> Address <u>721 Smith St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>500X Acute laryngo-tracheo bronchitis.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		2-27-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gracelawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>New Castle Co. Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co - Franklin Hill.</u>				24a. REC'D BY REGISTRAR DATE <u>2-27-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Halloway</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STANDARD STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
LOCAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

FEB 29 1956

RECEIVED

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INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02292

# CERTIFICATE OF DEATH

Dr. Wm Smith

2328

Reg. Dist. No.....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Wicomico</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Wicomico</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <b>Salisbury</b>		TOWN <b>Salisbury</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>R.D. # 3(Mt Hermon Rd)</b>		STREET ADDRESS (If rural give location) <b>R.D. # 3 (Mt. Hermon Rd)</b>	
3. NAME OF DECEASED (First) <b>NANNIE</b> (Middle) <b>GRACE</b> (Last) <b>HASTINGS</b>		4. DATE OF DEATH (Month) <b>FEB.</b> (Day) <b>3 rd</b> (Year) <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>October 5, 1885</b>
9. AGE last birthday <b>70</b> yrs.		IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Wicomico Co. Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Joshua G. Holloway</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Maria Holloway</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <b>Mr. Ananias Hastings (Husband) R.D. # 3 (Mt. Hermon Rd) Salisbury, Maryland</b>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
422.1 IMMEDIATE CAUSE (A) <b>Cardiac Failure</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>C.V. disease</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Insufficiency of Myo-cardial failure</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>2-1</b> , 19 <b>56</b> , to <b>2-3</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>2-3</b> , 19 <b>56</b> , and that death occurred at <b>2:35P</b> M, from the causes and on the date stated above.			
SIGNATURE <b>Wm B. Smith</b>		ADDRESS (Street, city, town, state) <b>Salisbury, Maryland</b>	
DATE SIGNED <b>Feb. 6 / 1956</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Feb. 5, 1956</b>	
NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. REC'D BY REGISTRAR <b>Mary T. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>	

# CERTIFICATE OF DEATH

Block 1000, 1000

1. NAME OF DECEASED (Print or Write)

2. SEX (Print or Write)

3. AGE (Print or Write)

4. DATE OF BIRTH (Print or Write)

5. PLACE OF BIRTH (Print or Write)

6. OCCUPATION (Print or Write)

7. CAUSE OF DEATH (Print or Write)

8. PLACE OF DEATH (Print or Write)

9. TIME OF DEATH (Print or Write)

10. SIGNATURE OF PHYSICIAN (Print or Write)

11. SIGNATURE OF REGISTRAR (Print or Write)

12. SIGNATURE OF WITNESS (Print or Write)

13. SIGNATURE OF DECEASED (Print or Write)

14. SIGNATURE OF NEXT OF KIN (Print or Write)

15. SIGNATURE OF OTHER (Print or Write)

16. SIGNATURE OF OTHER (Print or Write)

17. SIGNATURE OF OTHER (Print or Write)

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43. SIGNATURE OF OTHER (Print or Write)

44. SIGNATURE OF OTHER (Print or Write)

*Handwritten signature: E. V. Johnson*

BUREAU V. 2

FEB 7 1956

RECEIVED

*Handwritten signature: W. C. Smith*

*Handwritten signature: W. C. Smith*

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2329

## CERTIFICATE OF DEATH

02293

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>MD.</i>		COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X <i>Towson</i>		<i>Lifetime</i>		<i>Towson</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Exxie</i> <i>Heath</i>				<i>2-27-56</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>F</i>	<i>W</i>	<i>Married</i>	<i>9-26-1873</i>	<i>82</i> yrs.	<i>5</i> Months	<i>7</i> Days	<i>1</i> Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>		<i>Own Home</i>		<i>Maryland</i>		<i>U.S.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Julius Brady</i>				<i>Laura Messick</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>Yes</i>				<i>Moni Heath, Towson, Maryland</i>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.0 IMMEDIATE CAUSE (A) <i>Acute Cardiac Failure</i>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic Heart Disease</i>						<i>2 hours</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)						<i>5 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Acute Pulmonary Edema</i>						<i>2 hours</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5 Jan.</i> , 19 <i>54</i> , to <i>27 Feb.</i> , 19 <i>56</i> ; that I last saw the deceased alive on <i>27 Feb.</i> , 19 <i>56</i> , and that death occurred at <i>1:15 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Richard H. Saunders</i>				ADDRESS (Street, city, town, state) <i>Northcoke Md.</i>		DATE SIGNED <i>2/28/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>3-1-56</i>		<i>Towson Cem.</i>		<i>Towson, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>MAR 2 1956</i>		<i>Mary T. Holloway</i>		<i>R. D. Messick</i>		<i>Brownlee, Md.</i>	



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2293 CERTIFICATE OF DEATH

02294

Reg. Dist. No. 932

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WORCESTER</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>51 HOURS</u>		TOWN <u>POCOMOKE</u> <u>R.F.D. #2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>90 JAMES WEBB</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>KENNETH HEATH</u>				<b>4. DATE OF DEATH</b> (Month) <u>FEB</u> (Day) <u>27</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Aug 29 1953</u>	9. AGE last birthday <u>2</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>infant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Heath</u>				14. MOTHER'S MARDEN NAME <u>Fillie Former</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>George Heath Pocomoke, Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <u>0573 meningitis, meningococcie</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C) <u>Pneumonia, hemorrhagic</u>						<u>1 day</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>Feb 26</u> , 19 <u>56</u> , to <u>Feb 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 27</u> , 19 <u>56</u> , and that death occurred at <u>2:15</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>R. M. Sanchez</u>				ADDRESS (Street, city, town, state) <u>M.D. 12611 Division St, Salisbury</u>		DATE SIGNED <u>2/27/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>3-1-56</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Trinity</u>		LOCATION (City, town, or county) <u>Painter VA.</u>		(State)	
24. REC'D BY REGISTRAR <u>3-1-56</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>		ADDRESS		

# CERTIFICATE OF DEATH

DATE OF DEATH

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. CAUSE OF DEATH

4. MANNER OF DEATH

5. SEX

6. AGE

7. RACE

8. OCCUPATION

9. MARITAL STATUS

10. EDUCATION

11. RELIGION

12. BIRTH DATE

13. BIRTH PLACE

14. BIRTH TIME

15. BIRTH WEIGHT

16. BIRTH LENGTH

17. BIRTH HEAD CIRCUMFERENCE

18. BIRTH SKIN COLOR

19. BIRTH HAIR COLOR

20. BIRTH EYE COLOR

21. BIRTH NOSE COLOR

22. BIRTH MOUTH COLOR

23. BIRTH TEETH

24. BIRTH FINGERS

25. BIRTH TOES

26. BIRTH HEART

27. BIRTH LUNGS

28. BIRTH LIVER

29. BIRTH SPLEEN

30. BIRTH PANCREAS

31. BIRTH STOMACH

32. BIRTH SMALL INTESTINE

33. BIRTH LARGE INTESTINE

34. BIRTH RECTUM

35. BIRTH UTERUS

36. BIRTH VAGINA

37. BIRTH CERVIX

38. BIRTH VULVA

39. BIRTH CLITORIS

40. BIRTH PERINEUM

41. BIRTH ANUS

42. BIRTH PENIS

43. BIRTH TESTES

44. BIRTH PROSTATE

45. BIRTH BLADDER

46. BIRTH URETERS

47. BIRTH KIDNEYS

48. BIRTH ADRENALS

49. BIRTH THYROID

50. BIRTH PARATHYROID

51. BIRTH PITUITARY

52. BIRTH PINEAL

53. BIRTH HYPOTHALAMUS

54. BIRTH OPTIC NERVE

55. BIRTH OPTIC CHiasm

56. BIRTH OPTIC TRACT

57. BIRTH OPTIC GLOBE

58. BIRTH OPTIC DISC

59. BIRTH OPTIC CUP

60. BIRTH OPTIC NERVE FIBERS

61. BIRTH OPTIC NERVE SHEATH

62. BIRTH OPTIC NERVE ROOT

63. BIRTH OPTIC NERVE GLOBE

64. BIRTH OPTIC NERVE DISC

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217. BIRTH OPTIC NERVE SHEATH

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219. BIRTH OPTIC NERVE GLOBE

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221. BIRTH OPTIC NERVE CUP

222. BIRTH OPTIC NERVE FIBERS

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234. BIRTH OPTIC NERVE FIBERS

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239. BIRTH OPTIC NERVE CUP

240. BIRTH OPTIC NERVE FIBERS

241. BIRTH OPTIC NERVE SHEATH

242. BIRTH OPTIC NERVE ROOT

243. BIRTH OPTIC NERVE GLOBE

244. BIRTH OPTIC NERVE DISC

245. BIRTH OPTIC NERVE CUP

246. BIRTH OPTIC NERVE FIBERS

247. BIRTH OPTIC NERVE SHEATH

Dr. Fisher & Briele

2296

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>12</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>WATSON</b> Last <b>HILL</b>				4. DATE OF DEATH Month <b>February</b> Day <b>20th</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 31, 1871</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>19</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>On Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Sussex Co. Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin Hill</b>				14. MOTHER'S MAIDEN NAME <b>Amelia Records</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Samuel Williams (Daughter)</b> Address <b>214 Holland Ave. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Cholelithiasis &amp; Cholelithiasis</b> DUE TO (c) <b>Wound disruption</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/24/56</b> , 19____, to <b>2/20/56</b> , 19____, that I last saw the deceased alive on <b>2/20/56</b> , 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>Feb. 21 1956</b>							
ACTUAL SIGNATURE <b>Dr. Henry A. Briele</b> PHYSICIAN'S NAME (Type) <b>Dr. William H. Fisher Jr.</b>				M.D. <b>Medical Center</b> <b>Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 22, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b> 24a. REC'D BY REGISTRAR <b>FEB 23 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF CLERK		14. SIGNATURE OF WITNESSES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02296

2330

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH, o. COUNTY <u>Wicomico</u> <u>MD.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Wicomico Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Allen</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Allen Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>Henry</u> First <u>Harjis</u> Middle <u>Joseph</u> Last				4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-8-1895</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Somerset Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>217-103642</u>		17. INFORMANT <u>Ruth Walker</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> <u>177x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prostatic carcinoma.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>July 11, 1955</u> , to <u>19</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.							
PHYSICIAN'S NAME (Type) <u>O. J. Burton, M.D.</u>				<u>211 Maryland Ave. Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 1, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Pot Office</u>		22d. LOCATION (City, town, or county) (State) <u>West Pot Office MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Becker M. West</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>3-5-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>			

BUREAU V. S.

MAR 8 1956

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 2331 CERTIFICATE OF DEATH

02297

335

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SHARPTOWN</u>		<u>75 yrs</u>		TOWN <u>SHARPTOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>School ST</u>				STREET ADDRESS (If rural give location) <u>School ST</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>DELLA</u> (Middle) <u>JACKSON</u> (Last) <u>HOWARD</u>				(Month) <u>FEB</u> (Day) <u>18</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAR 27, 1866</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES BOUNDS</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH PHILLIPS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>HOME</u>		17. INFORMANT & ADDRESS <u>E. ROWE HOWARD JR.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 day.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Arterio Sclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>7/16</u> , 19 <u>56</u> , to <u>7/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/18</u> , 19 <u>56</u> , and that death occurred at <u>7P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Dr. Kuhlman</u>		M.D.		ADDRESS (Street, city, town, state) <u>Sharptown MD</u>		DATE SIGNED <u>7/26/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2/22/56</u>		NAME OF CEMETERY OR CREMATORY <u>FIREMENS</u>		LOCATION (City, town, or county) (State) <u>SHARPTOWN MD</u>	
24. REC'D BY REGISTRAR <u>FEB 27 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. Mary Owens</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Phil Smith</u>		ADDRESS <u>Sharptown MD</u>	



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02298

## 2297 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>1 day</u>		TOWN <u>SALISBURY</u>		<u>RD #4 x</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>SNOW HILL ROAD</u>			
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>MARIE-ESTELLA - HUBBARD</u>				<u>FEB 16 1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>7</u>	<u>WHITE</u>	<u>Widowed</u>	<u>OCT 20-1886</u>	<u>69</u> yrs.	Months <u>3</u>	Days <u>26</u>	Hours <u></u> Min. <u></u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Palmer</u>		<u>at own home</u>		<u>Virginia</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>John Kennedy</u>				<u>Lillian Rebecca Loring</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
<u>No</u>				<u></u>		<u>Mrs. Mary J. De Forge (Sister)</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE (A)</b>				<u>Coronary Thrombosis</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>				<u>Congestive Heart Failure</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO</b>							
<b>(C)</b>							
<b>18 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>19c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Feb 14</u>, 19<u>56</u>, to <u>Feb 16</u>, 19<u>56</u>, that I last saw the deceased alive on <u>2/16/56</u>, 19<u>56</u>, and that death occurred at <u>11:58</u> A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Dr. Carrie L. Hearn M.D.</u>		<u>Feb 20 1956</u>		<u>Wicomico Mem. Park Salisbury Md.</u>		<u>2/17/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>24. REC'D BY REGISTRAR</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Burial</u>		<u>Mary H. Hallaway</u>		<u>Hollway &amp; Co. Salisbury Md.</u>			
<b>DATE</b>		<b>20 FEB 1956</b>					

# DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

Reg. Dist. No.

1. NAME AND RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF DECEASED

12. SIGNATURE OF REGISTRAR

BUREAU V. S.

FEB 20 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02299

## 2298 CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>2 months</u>		TOWN <u>East New Market</u>		<u>09X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Maud</u>		(Middle) <u>Mary</u>		(Last) <u>Johnson</u>		<u>Feb.</u> <u>9</u> <u>1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Colored</u>	<u>Widowed</u>	<u>6/20/1893</u>	<u>62</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Housework</u>		<u>North Carolina</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Ellick Herndon</u>				<u>Roxie Anna Mayo</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>-</u>		<u>Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
023X IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				<u>3 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				<u>?</u>			
(C) <u>Lues, generalized</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchopneumonia</u>				<u>2 weeks</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>-</u>		<u>-</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>-</u>		<u>-</u>		<u>-</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>-</u>		<u>-</u>		<u>-</u>			
22. I hereby certify that I attended the deceased from <u>Dec. 5</u> , 19 <u>55</u> , to <u>Feb. 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/9/56</u> , 19 <u>56</u> , and that death occurred at <u>9:40P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>2/10/56</u>			
M.D. <u>Deer's Head Hospital, Salisbury, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/13/56</u>		<u>East New Market</u>		<u>East New Market, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>B 16 1956</u>		<u>Mary Holloway</u>		<u>[Signature]</u>		<u>East New Market, Md</u>	

# CERTIFICATE OF DEATH

Page One of Two

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF CHURCH OFFICIAL

19. SIGNATURE OF FUNERAL HOME

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02460

## 2299 CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (If this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		4½ years		TOWN <u>Baltimore</u>		3401-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>1333 N. Carey Street</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
Mary Jones				Feb. 23 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	Colored	Single	12/22/73	82 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Cook		Cooking		Virginia		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Peter Jones				Susan Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk.		-		Hospital Records			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
422.1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, general</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						?	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Elephantiasis of left leg due to lymphangiectasis</u>						5 yrs ?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 14, 1951</u> , to <u>Feb. 23, 1956</u> , that I last saw the deceased alive on <u>Feb. 23, 1956</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. H. H. Huerman</u>		M.D. <u>Deer's Head State Hospital</u>		ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>2/24/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/27/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Luke's, Reisterstown, Md.</u>		LOCATION (City, town, or county) <u>St. Joseph &amp; Russ</u>	
24. REC'D BY REGISTRAR <u>Mary H. Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>2222 W. North ave</u>		ADDRESS <u>Baltimore</u>	
DATE <u>MAR 1 1956</u>							

# CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

INSTRUCTIONS

1. This certificate is to be filled out by the attending physician or other qualified person who has attended the deceased during the last illness. It should be filled out as soon as possible after death, and before the body is buried or cremated. It is a legal document and its contents are subject to the laws of the State of New York.

BUREAU V. 1

MAR 1 1956

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## CERTIFICATE OF DEATH

Reg. Dist. No.

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2300

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
c. LENGTH OF STAY IN lb <u>3 Days</u>				d. STREET ADDRESS <u>414 Forest Lane</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>HAGER</u> Last <u>LANCE</u>				4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 9, 1871</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Hager</u>				14. MOTHER'S MAIDEN NAME <u>Unknow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Olive Galbraith, 414 Forest Lane, Sal. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforated Peptic Ulcer</u> 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/24</u> , 19 <u>56</u> , to <u>2/26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/26</u> , 19 <u>56</u> , and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Fred R. Gramse</u> M.D. <u>Salisbury, Md.</u>				DATE SIGNED <u>2/27/56</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Fred R. Gramse, 402 South Division St., Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill &amp; Johnson Co., Salisbury, Maryland</u> <u>Norman F. Baker</u>				24a. REC'D BY REGISTRAR <u>DATE 2-27-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollomay</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2190

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to blurring and bleed-through.

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INSTRUCTIONS

**1** executed within **24** hours after death.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**VS A15C 1-55 10M**

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02302

## 2301 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				OR TOWN <u>Pocomoke (RURAL)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Box 418</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>J.</u> (Middle) <u>Miles</u> (Last) <u>Sanford</u>				(Month) <u>February</u> (Day) <u>17</u> (Year) <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>FEBRUARY 25, 1904</u>	9. AGE last birthday <u>51</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FEED DEALER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD D. WANKFORD</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN J. MORRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-32-0173</u>		17. INFORMANT & ADDRESS <u>MRS. ESTHER WANKFORD</u> <u>POCOMOKE CITY, MARYLAND</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Myocardial Infarct acute</u>				<u>6 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-5</u> , 19 <u>56</u> , to <u>2-17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-17</u> , 19 <u>56</u> , and that death occurred at <u>4:20 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>William R. Ellis, Jr.</u> M.D.		ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>2-17-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>FEB. 20, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN CEMETERY</u>		LOCATION (City, town, or county) <u>POCOMOKE CITY, MD.</u>		(State)	
24. REC'D BY REGISTRAR <u>Mary H. Holloway</u>	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		ADDRESS <u>(Pocomoke Md.)</u>			
DATE <u>2-21-1956</u>							

# CERTIFICATE OF DEATH

1. USUAL RESIDENCE (HOUSE OR APARTMENT)

2. PLACE OF DEATH

3. CAUSE OF DEATH

4. MANNER OF DEATH

5. SEX

6. AGE

7. DATE OF BIRTH

8. TIME OF DEATH

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**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**1** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02303

## 2332 CERTIFICATE OF DEATH

Dr. Beardsley

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		STATE <b>MARYLAND</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place) <b>3 (E.Vine St Ext.)</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		TOWN <b>Salisbury</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>R.D. # 3 (E.Vine St Ext.)</b>				STREET ADDRESS (If rural give location) <b>R.D. # 3</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>SARAH</b>		<b>VIRGINIA</b>		<b>LESTER</b>		<b>FEB. 13 th 19 56</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>May 20, 1862</b>	<b>9. AGE last birthday</b> <b>93 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Work</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>at own home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>Robert Cooper</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Octavia Thompson</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Oscar Fooks-Daughter-R.D. # 3 Salisbury, Maryland</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>331X IMMEDIATE CAUSE (A)</b> <b>corneal hemorrhage</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 day</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>							
<b>STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 2-13, 1955, to 2-13, 1956, that I last saw the deceased alive on 2-13, 1956, and that death occurred at 2 P.M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Dr. Beardsley</i>				<b>ADDRESS</b> (Street, city, town, state) <b>DATE SIGNED</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>M.D. Maryland Ave. Salisbury, Maryland Feb. 13 / 1956</b>			
<b>24. REC'D BY REGISTRAR</b> <b>FEB 13 1956</b>		<b>DATE THEREOF</b> <b>Feb. 16, 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Parsons Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Salisbury, Maryland</b>	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Mary H. Holloway</i>		<b>REGISTERAR'S SIGNATURE</b> <i>Mary H. Holloway</i>		<b>ADDRESS</b> <b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>			

# CERTIFICATE OF DEATH

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. RACE  
5. OCCUPATION  
6. PLACE OF BIRTH  
7. DATE OF BIRTH  
8. DATE OF DEATH  
9. PLACE OF DEATH  
10. CAUSE OF DEATH  
11. MANNER OF DEATH  
12. SIGNATURE OF PHYSICIAN  
13. SIGNATURE OF REGISTRAR  
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BUREAU V. 2

FEB 15 1956

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Royer, Earl (Med. Exam) 2333

02304

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <b>Rural</b>		<b>Salisbury</b>		TOWN <b>Salisbury</b>		<b>Rural</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Naylor Road</b>				STREET ADDRESS (If rural, give location) <b>Spring Hill Rd. (U.S.# 50)</b>			
3. NAME OF DECEASED:		(First)		(Middle)		(Last)	
(Type or Print)		<b>JAMES</b>		<b>W</b>		<b>LEWIS</b>	
4. DATE OF DEATH		(Month)		(Day)		(Year)	
<b>Feb.</b>		<b>18</b>		<b>th</b>		<b>19 56</b>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<b>Male</b>		<b>White</b>		<b>Married</b>		<b>Feb. 25, 1904</b>	
9. AGE last birthday:		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<b>51</b>		<b>Landscape Contractor (Nurseryman)</b>		<b>Farmer North Carolina</b>		<b>USA</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>Charles L. Lewis</b>				<b>Elizabeth McMaster</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<b>Unk</b>				<b>Mrs. Mary Lewis (Wife) Spring Hill Rd (US#50) Salisbury, Maryland</b>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN DEATH	
Immediate cause (a) <b>Bullet wound of Brain</b>						<b>8 hrs</b>	
DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg, etc.)		21c. (City or town)		(Country)	
<input type="checkbox"/>		<b>Street</b>		<b>Salisbury</b>		<b>Wicomico Md</b>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>2 18 56 5P. M.</b>				<b>Shot self w rifle</b>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>Earl Royer</b>				M. D. <b>CHIEF MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> DATE SIGNED <b>Feb. 20 1956</b>			
23. BURIAL, CREMATION, REMOVAL (Specify):				24. FUNERAL DIRECTOR ADDRESS			
<b>Burial</b>				<b>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</b>			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE					
<b>2-20-56</b>		<b>Mary W. Holloway</b>					

BUREAU V. S.

FEB 23 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 9, Film G193 2-27-56 et  
CERTIFICATE OF DEATH

02305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>1 Wk</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Hill Private Sanatorium</b>				d. STREET ADDRESS <b>1000 John St.,</b>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Ralph</b> Last <b>Mace, Sr.</b>				4. DATE OF DEATH Month <b>2</b> Day <b>19</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 22, 1985</b>	
9. AGE (In years last birthday) <b>70 69</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seed Store</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>George Mace</b>				14. MOTHER'S MAIDEN NAME <b>Josphine Taubman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-8111</b>		17. INFORMANT Address <b>Mrs. J. Ralph Mace, Sr. Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular renal disease</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1948</b> , to <b>2-19</b> , <b>1956</b> , that I last saw the deceased alive on <b>2-18</b> , <b>1956</b> , and that death occurred at <b>3 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip A. Insley</b> M.D.				ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b>			
DATE SIGNED <b>2-20-56</b>							
PHYSICIAN'S NAME (Type) <b>Dr. Philip A. Insley 116 East Main St., Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/21/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>East New Market, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Norman F. Baber</b>				ADDRESS <b>The Hill &amp; Johnson Co. Salisbury, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>2-20-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary W. Looman</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	
JOHN J. JONES		M		45		JAN 15 1911		BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL		HOME		FEB 10 1956		10:30 AM		J. J. JONES		J. J. JONES		J. J. JONES	
FATHER		M		75		JAN 15 1881		BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL		HOME		FEB 10 1956		10:30 AM		J. J. JONES		J. J. JONES		J. J. JONES	
MOTHER		F		70		JAN 15 1886		BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL		HOME		FEB 10 1956		10:30 AM		J. J. JONES		J. J. JONES		J. J. JONES	
SISTER		F		40		JAN 15 1916		BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL		HOME		FEB 10 1956		10:30 AM		J. J. JONES		J. J. JONES		J. J. JONES	
BROTHER		M		35		JAN 15 1921		BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL		HOME		FEB 10 1956		10:30 AM		J. J. JONES		J. J. JONES		J. J. JONES	
SISTER		F		30		JAN 15 1926		BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL		HOME		FEB 10 1956		10:30 AM		J. J. JONES		J. J. JONES		J. J. JONES	
BROTHER		M		25		JAN 15 1931		BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL		HOME		FEB 10 1956		10:30 AM		J. J. JONES		J. J. JONES		J. J. JONES	
SISTER		F		20		JAN 15 1936		BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL		HOME		FEB 10 1956		10:30 AM		J. J. JONES		J. J. JONES		J. J. JONES	
BROTHER		M		15		JAN 15 1941		BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL		HOME		FEB 10 1956		10:30 AM		J. J. JONES		J. J. JONES		J. J. JONES	
SISTER		F		10		JAN 15 1946		BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL		HOME		FEB 10 1956		10:30 AM		J. J. JONES		J. J. JONES		J. J. JONES	
BROTHER		M		5		JAN 15 1951		BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL		HOME		FEB 10 1956		10:30 AM		J. J. JONES		J. J. JONES		J. J. JONES	
SISTER		F		0		JAN 15 1956		BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL		HOME		FEB 10 1956		10:30 AM		J. J. JONES		J. J. JONES		J. J. JONES	

BUREAU V. S.

FEB 23 1956

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 2303 CERTIFICATE OF DEATH

02306

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>34</u> years		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>06X-2</u>			
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(First) <u>Ella</u>		(Middle) <u>Irene</u>		(Last) <u>Martin</u>		(Month) (Day) (Year) <u>Feb. 14 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1/3/1877</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Union Bridge, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Martin</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Stansbury</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, generalized</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Multiple decubital ulcers</u>						<u>6 months</u>	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>-</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>-</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>-</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>-</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>-</u>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Nov. 11</u> , 19 <u>52</u> , <b>to</b> <u>Feb. 14</u> , 19 <u>56</u> , <b>that I last saw the deceased alive on</b> <u>Feb. 14</u> , 19 <u>56</u> , <b>and that death occurred at</b> <u>8:50 A.M.</u> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>L.V. Maldve, M.D.</u> <b>ADDRESS</b> (Street, city, town, state) <u>Deer's Head State Hospital, Salisbury, Maryland</u> <b>DATE SIGNED</b> <u>2/14/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>2/17/56</u>		NAME OF CEMETERY OR CREMATORY <u>Int. View Cemetery</u>		LOCATION (City, town, or county) (State) <u>Union Bridge, Md.</u>	
24. REC'D BY REGISTRAR <u>EB 23 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>DD Fritz</u>		ADDRESS <u>Union Bridge Md</u>	

CERTIFICATE OF DEATH

1953

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Usual residence

7. Date of death

8. Place of death

9. Cause of death

10. Manner of death

11. Signature of physician

12. Signature of registrar

13. Signature of coroner

14. Signature of medical examiner

15. Signature of health officer

16. Signature of funeral director

17. Signature of undertaker

18. Signature of cemetery

19. Signature of burial place

20. Signature of interment

21. Signature of final disposition

22. Signature of final resting place

23. Signature of final burial

24. Signature of final interment

25. Signature of final disposition

26. Signature of final resting place

27. Signature of final burial

28. Signature of final interment

29. Signature of final disposition

30. Signature of final resting place

31. Signature of final burial

32. Signature of final interment

33. Signature of final disposition

34. Signature of final resting place

35. Signature of final burial

36. Signature of final interment

37. Signature of final disposition

38. Signature of final resting place

39. Signature of final burial

40. Signature of final interment

41. Signature of final disposition

42. Signature of final resting place

43. Signature of final burial

44. Signature of final interment

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Usual residence

7. Date of death

8. Place of death

9. Cause of death

10. Manner of death

11. Signature of physician

12. Signature of registrar

13. Signature of coroner

14. Signature of medical examiner

15. Signature of health officer

16. Signature of funeral director

17. Signature of undertaker

18. Signature of cemetery

19. Signature of burial place

20. Signature of interment

21. Signature of final disposition

22. Signature of final resting place

23. Signature of final burial

24. Signature of final interment

25. Signature of final disposition

26. Signature of final resting place

27. Signature of final burial

28. Signature of final interment

29. Signature of final disposition

30. Signature of final resting place

31. Signature of final burial

32. Signature of final interment

33. Signature of final disposition

34. Signature of final resting place

35. Signature of final burial

36. Signature of final interment

37. Signature of final disposition

38. Signature of final resting place

39. Signature of final burial

40. Signature of final interment

41. Signature of final disposition

42. Signature of final resting place

43. Signature of final burial

44. Signature of final interment

RECEIVED  
FEB 23 1956  
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02307

Dr. Lawry

2334

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>00 S. Division St Ext. (P.O.B.# 11)</b>				d. STREET ADDRESS <b>S. Division St Ext. (P.O.B.# 11)</b>			
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>THOMAS</b> Last <b>MATTHEWS</b>				4. DATE OF DEATH Month <b>FEB.</b> Day <b>28th</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 23, 1870</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months <b>4</b> Days <b>3</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Store Merchant</b>		11. BIRTHPLACE (State or foreign country) <b>Accomac Co. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Matthews</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Collins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Edward S. Matthews (Son) S. Division St Ext. (P.O.B.# 11) Fruitland, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4341 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <b>Smoking</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> , to <b>death</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>2-27-56</b> , and that death occurred at <b>1:00A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lee Lawry</b> M.D.				ADDRESS (Street, city or town, state) <b>Fruitland, Maryland</b> DATE SIGNED <b>Feb. 28 1956</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Lee Lawry M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 1, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>			
24a. REC'D BY REGISTRAR <b>MAR 2 1956</b>				24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			

BUREAU V. S.

1956 2 MAR

RECEIVED

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02308

## 2304 CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>1 1/2</u> years		TOWN <u>Crisfield</u>		<u>19-39-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>Chesapeake Avenue</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Willie Anna Milbourne</u>				<u>Feb. 2 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>11/9/1864</u>	<u>91</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>-</u>			<u>-</u>		<u>Maryland</u>		<u>USA</u>
13. FATHER'S NAME <u>John McClemmy</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk</u>		<u>-</u>		<u>Hospital Records</u>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u>						<u>?</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Old intertrochanteric fracture of right femur</u>						<u>4 months</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>-</u>		<u>-</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>-</u>		<u>-</u>		<u>-</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>-</u>		<u>M.</u>		<u>-</u>			
22. I hereby certify that I attended the deceased from <u>Aug. 24</u> , 19 <u>54</u> , to <u>Feb. 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 12</u> , 19 <u>56</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve</u>		ADDRESS (Street, city, town, state) <u>Salisbury Md.</u>		DATE SIGNED <u>2/2/56</u>			
M.D. <u>Deer's Head State Hospital</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 4, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Crisfield Cemetery</u>		LOCATION (City, town, or county) (State) <u>Crisfield, Maryland</u>	
24. REC'D BY REGISTRAR <u>2-8-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Bradshaw &amp; Sons--Crisfield, Md.</u>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

BUREAU V. S.

FEB 9 1956

RECEIVED

CERTIFICATE OF DEATH

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02309

## 2305 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>VIRGINIA</u>		COUNTY <u>Accomac</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>		LENGTH OF STAY (In this place) <u>1 3/4 HOURS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PARKSLEY</u>		<u>83X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>LOLA SCOTT PARKS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 25 19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>SEPT. 9, 1894</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Lady</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Parksley, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frances Edward Scott</u>				14. MOTHER'S MAIDEN NAME <u>Malisha Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>277-05-3397</u>		17. INFORMANT & ADDRESS <u>Mrs Nellie S. Guy, Parksley Va.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>2 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Insufficiency</u>						<u>3 wks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Coronary Sclerosis</u> ✓						<u>yes</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic Cardio-Vascular Disease</u>						<u>"</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/25</u> , 19 <u>56</u> , to <u>2/25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/25</u> , 19 <u>56</u> , and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u> Rufus L. Gardner, Jr.</u>				ADDRESS (Street, city, town, state) <u>3215 Div. St., Salisbury, Md.</u>		DATE SIGNED <u>2/26/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2/28/56</u>		NAME OF CEMETERY OR CREMATORY <u>Parksley</u>		LOCATION (City, town, or county) (State) <u>Parksley Va.</u>	
24. REC'D BY REGISTRAR DATE: <u>2-29-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry M. Johnson</u>		ADDRESS	

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ONLINE

# IDEA

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## CONCLUSIONS

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 145 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02310

## 2306 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>WORCESTER</u>	
CITY (If outside corporate limits, write RURAL or give nearest town) <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>16 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		<u>23X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>FRANKLIN AVE</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Daisy</u> (First) <u>ROSELLE</u> (Middle) <u>POWELL</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>2</u> (Day) <u>16</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b> <u>JAN. 1, 1897</u>	<b>9. AGE last birthday</b> <u>59</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>BERLIN MD. RFD</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>JESSE Birch</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>ARALANTA MERRITT</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b> <u>218-05-8579</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Miss Nellie Powell, BERLIN MD.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>572.1 IMMEDIATE CAUSE (A)</b> <u>Myocardial Insufficiency</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 yrs.</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Cor pulmonale + Hypertension</u>						<u>Unknown</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>Chronic Bronchitis + Emphysema</u>						<u>11</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Evisceration following Bowel resection</u>							
<b>19a. DATE OF OPERATION</b> <u>Feb. 7 1956</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>Ninerticuli with large bowel obstruction</u>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Jan. 1953</u> to <u>Feb. 16, 1956</u> that I last saw the deceased alive on <u>Feb. 16, 1956</u> and that death occurred at <u>4:50 PM</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>David Selmon</u>		<b>DATE THEREOF</b> <u>2/19/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>EVERGREEN</u>		<b>LOCATION (City, town, or county) (State)</b> <u>BERLIN MD</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>24. REC'D BY REGISTRAR</b> <u>May 21, 1956</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Anna A. Burbage</u>		<b>ADDRESS</b> <u>Berlin Md</u>	

CERTIFICATE OF DEATH

Name of Deceased: **TERSE BIRCH**  
 Date of Death: **Jan. 1, 1947**  
 Place of Death: **General Hospital**  
 Cause of Death: **Heart Disease**  
 Age: **72**  
 Sex: **Female**  
 Race: **White**  
 Marital Status: **Wife**  
 Occupation: **Housewife**  
 Address: **1025 W. 24th St., Baltimore, Md.**  
 Signature of Physician: *[Signature]*  
 Signature of Registrar: *[Signature]*  
 Date: **Feb. 1, 1947**  
 Bureau V. S.

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 EVERETT  
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 1025 W. 24th St.  
 Baltimore, Md.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02312

## 2307 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Worcester.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SALISBURY</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke</u>		<u>23-42-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA General Hospital</u>				STREET ADDRESS (If rural give location) <u>705 Clark Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Robert A Pusey.</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>February 21 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>NOV 5 1916</u>	9. AGE last birthday <u>39</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTO MECHANIC</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>ERNEST R. PUSEY</u>				14. MOTHER'S MAIDEN NAME <u>LAURA V. BUTLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-76-7369</u>		17. INFORMANT & ADDRESS <u>MRS AUDREY D. PUSEY</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A) <u>Myocardial Infarct, acute</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hours</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>2/20/56</u> , <b>19</b> <u>56</u> , <b>to</b> <u>2/21/56</u> , <b>19</b> <u>56</u> , <b>that I last saw the deceased alive on</b> <u>2/20/56</u> , <b>19</b> <u>56</u> , <b>and that death occurred at</b> <u>9:20 A.M.</u> , <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>William R. Ellis, Jr.</u> M.D. <u>Salisbury, Md.</u> <b>DATE SIGNED</b> <u>2-21-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/23/56</u>		NAME OF CEMETERY OR CREMATORY <u>Portersville M.E. Cem.</u>		LOCATION (City, town, or county) (State) <u>Portersville Md.</u>	
24. REC'D BY REGISTRAR <u>FEB 24 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry D. Watson</u>		ADDRESS <u>(Pocomoke Md.)</u>	

NOTIFICATION

THIS OFFICE HAS BEEN ADVISED BY THE BUREAU OF VITAL STATISTICS, STATE OF MARYLAND, THAT THE DEATH OF [REDACTED] HAS BEEN REPORTED. THE DEATH OCCURRED ON [REDACTED] AT [REDACTED]. THE CAUSE OF DEATH WAS [REDACTED]. THE DEATH WAS REPORTED BY [REDACTED]. THE DEATH WAS CERTIFIED BY [REDACTED]. THE DEATH WAS REPORTED TO THE BUREAU OF VITAL STATISTICS, STATE OF MARYLAND, ON [REDACTED]. THE DEATH WAS REPORTED TO THE BUREAU OF VITAL STATISTICS, STATE OF MARYLAND, ON [REDACTED].

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE, MD  
1956  
CERTIFICATE OF DEATH

Year 1956

1. NAME OF DECEASED

2. SEX

3. RACE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

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BUREAU V. S.

FEB 24 1956

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INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 2335 CERTIFICATE OF DEATH

02313

Item 8, Film G193 3-1-56 et

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <i>MARDELA</i>		<i>60 yrs</i>		TOWN <i>MARDELA</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>BRIDGE ST</i>				STREET ADDRESS (If rural give location) <i>BRIDGE ST.</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>CHARLES THOMAS REDDISH</i> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>FEB 14 1956</i>			
<b>5. SEX</b> <i>M</i>	<b>6. COLOR OR RACE</b> <i>W</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>MARRIED</i>	<b>8. DATE OF BIRTH</b> <i>1890 SEPT 5, 1891</i>		<b>9. AGE last birthday</b> <i>65 yrs.</i>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>MILL</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>MD</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.</i>	
<b>13. FATHER'S NAME</b> <i>John REDDISH</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>UNKNOWN</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>YES</i> (If Yes, give year or dates of service) <i>1st WORLD WAR</i>		<b>16. SOCIAL SECURITY NO.</b> <i>-</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>MRS MARY REDDISH</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>IMMEDIATE CAUSE</b> (A) <i>422.2</i>				<i>Infarction of R. Jugular vein</i>		<i>1 Hour</i>	
<b>ANTECEDENT CAUSE(S)</b> DUE TO (B) <i>Chronic Myocarditis</i>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> DUE TO (C) <i>STATING UNDERLYING CAUSE LAST.</i>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>Feb 13</i>, 19<i>56</i>, to <i>Feb 14</i>, 19<i>56</i>, that I last saw the deceased alive on <i>Feb 13</i>, 19<i>56</i>, and that death occurred at <i>1:25</i> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>W. A. Spitznagel</i>				<b>ADDRESS</b> (Street, city, town, state) <i>Mardele Springs, MD</i>		<b>DATE SIGNED</b> <i>2/15/56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>BURIAL</i>		<b>DATE THEREOF</b> <i>2/16/56</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Mardele Springs</i>		<b>LOCATION (City, town, or county) (State)</b> <i>MARDELA SPRINGS, MD</i>	
<b>24. REC'D BY REGISTRAR</b> <i>5-11-1956</i>		<b>REGISTRAR'S SIGNATURE</b> <i>Mary McHolloway</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Karl J. Smith</i>		<b>ADDRESS</b> <i>Mardele Springs, MD</i>	
<b>DATE</b>							

# CERTIFICATE OF DEATH

1956

Form 100-10

1. NAME AND RESIDENCE OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF CLERK

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DEPUTY SHERIFF

18. SIGNATURE OF CONSTABLE

19. SIGNATURE OF JAILER

20. SIGNATURE OF WARDEN

21. SIGNATURE OF CHIEF OF POLICE

22. SIGNATURE OF DEPUTY CHIEF OF POLICE

23. SIGNATURE OF SQUAD LEADER

24. SIGNATURE OF OFFICER

25. SIGNATURE OF DETECTIVE

26. SIGNATURE OF PATROLMAN

27. SIGNATURE OF TRAFFIC OFFICER

28. SIGNATURE OF INVESTIGATOR

29. SIGNATURE OF ANALYST

30. SIGNATURE OF LABORATORY ASSISTANT

31. SIGNATURE OF CLERK

32. SIGNATURE OF RECEPTIONIST

33. SIGNATURE OF TELEPHONE OPERATOR

34. SIGNATURE OF MAIL ROOM CLERK

35. SIGNATURE OF JANITOR

36. SIGNATURE OF GARDENER

37. SIGNATURE OF COOK

38. SIGNATURE OF BUTLER

39. SIGNATURE OF HOUSEKEEPER

40. SIGNATURE OF MAINTENANCE MAN

41. SIGNATURE OF ELECTRICIAN

42. SIGNATURE OF PLUMBER

43. SIGNATURE OF PAINTER

44. SIGNATURE OF CARPENTER

45. SIGNATURE OF ROOFER

46. SIGNATURE OF TILER

47. SIGNATURE OF GLAZIER

48. SIGNATURE OF JOINER

49. SIGNATURE OF MILLWRIGHT

50. SIGNATURE OF BLACKSMITH

51. SIGNATURE OF WHEELWRIGHT

52. SIGNATURE OF COBBLER

53. SIGNATURE OF HATTER

54. SIGNATURE OF SHOE REPAIRER

55. SIGNATURE OF DRESSMAKER

56. SIGNATURE OF MILLINER

57. SIGNATURE OF HAIR DRESSER

58. SIGNATURE OF BEAUTICIAN

59. SIGNATURE OF NAIL TECHNICIAN

60. SIGNATURE OF COSMETOLOGIST

61. SIGNATURE OF MASSAGE THERAPIST

62. SIGNATURE OF CHIROPRACTOR

63. SIGNATURE OF YOGI

64. SIGNATURE OF MEDITATION INSTRUCTOR

65. SIGNATURE OF REIKI PRACTITIONER

66. SIGNATURE OF THERAPEUTIC MASSAGE THERAPIST

67. SIGNATURE OF AROMATHERAPY PRACTITIONER

68. SIGNATURE OF HERBAL MEDICINE PRACTITIONER

69. SIGNATURE OF ACUPUNCTURIST

70. SIGNATURE OF CHINESE MEDICINE PRACTITIONER

71. SIGNATURE OF JAPANESE MEDICINE PRACTITIONER

72. SIGNATURE OF KOREAN MEDICINE PRACTITIONER

73. SIGNATURE OF VIETNAMESE MEDICINE PRACTITIONER

74. SIGNATURE OF THAI MEDICINE PRACTITIONER

75. SIGNATURE OF BURMESE MEDICINE PRACTITIONER

76. SIGNATURE OF SINGAPORE MEDICINE PRACTITIONER

77. SIGNATURE OF MALAYSIAN MEDICINE PRACTITIONER

78. SIGNATURE OF INDIAN MEDICINE PRACTITIONER

79. SIGNATURE OF PAKISTANI MEDICINE PRACTITIONER

80. SIGNATURE OF BANGLADESHI MEDICINE PRACTITIONER

81. SIGNATURE OF NEPALESE MEDICINE PRACTITIONER

82. SIGNATURE OF SRI LANKAN MEDICINE PRACTITIONER

83. SIGNATURE OF MALAY MEDICINE PRACTITIONER

84. SIGNATURE OF JAVANESE MEDICINE PRACTITIONER

85. SIGNATURE OF SUMATRESE MEDICINE PRACTITIONER

86. SIGNATURE OF BALINESE MEDICINE PRACTITIONER

87. SIGNATURE OF SUDANESE MEDICINE PRACTITIONER

88. SIGNATURE OF ETHIOPIAN MEDICINE PRACTITIONER

89. SIGNATURE OF SOMALI MEDICINE PRACTITIONER

90. SIGNATURE OF KENYAN MEDICINE PRACTITIONER

91. SIGNATURE OF TANZANIAN MEDICINE PRACTITIONER

92. SIGNATURE OF UGANDAN MEDICINE PRACTITIONER

93. SIGNATURE OF RWANDAN MEDICINE PRACTITIONER

94. SIGNATURE OF BURUNDIAN MEDICINE PRACTITIONER

95. SIGNATURE OF CONGOLESE MEDICINE PRACTITIONER

96. SIGNATURE OF ZAMBIAN MEDICINE PRACTITIONER

97. SIGNATURE OF ZIMBABWEAN MEDICINE PRACTITIONER

98. SIGNATURE OF BOTSWANAN MEDICINE PRACTITIONER

99. SIGNATURE OF NAMIBIAN MEDICINE PRACTITIONER

100. SIGNATURE OF SOUTH AFRICAN MEDICINE PRACTITIONER

101. SIGNATURE OF LESOTHO MEDICINE PRACTITIONER

102. SIGNATURE OF SWAZI MEDICINE PRACTITIONER

103. SIGNATURE OF MALAGASY MEDICINE PRACTITIONER

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244. SIGNATURE OF MAURITIAN MEDICINE PRACTITIONER

245. SIGN

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2308

## CERTIFICATE OF DEATH

Reg. Dist. No. 02314  
337  
200

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Millington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Florence A. Roeder</u>				<u>Feb. 1 19 56</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>2/18/1867</u>	<u>88</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Unknown</u>		<u>-</u>		<u>Maryland</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>? Webb</u>				<u>?</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>Unk.</u>				<u>Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Acute myocardial insufficiency</u>						<u>24 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardiovascular disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<u>?</u>	
<u>Old fracture of right femur</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<u>-</u>		<u>-</u>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	
<u>-</u>		<u>-</u>		<u>-</u>		<u>-</u>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<u>-</u>		<u>-</u>		<u>-</u>			
<b>22. I hereby certify that</b> attended the deceased from <u>Oct. 17</u> , 19 <u>50</u> , to <u>Feb. 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 31</u> , 19 <u>56</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above.							
<b>SIGNATURE</b>		<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>			
<u>L.V. Maldve</u>		<u>L.V. Maldve, M.D.</u>		<u>2/1/56</u>			
<u>M.D. Deer's Head Hospital, Salisbury, Md.</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>removal</u>		<u>Feb 4 1956</u>		<u>Shrewsbury</u>		<u>Rd Kennedysville md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Feb. 31 1956</u>		<u>Edward Tellow</u>		<u>Edward Tellow</u>		<u>Millington Md.</u>	

Mary D. Holloway

# CERTIFICATE OF DEATH

5308

1. Name of deceased	2. Sex	3. Race
4. Date of birth	5. Date of death	6. Place of death
7. Cause of death	8. Signature of physician	9. Signature of registrar

10. Name of informant	11. Address of informant	12. Signature of informant
13. Name of funeral home	14. Address of funeral home	15. Signature of funeral home

16. Name of hospital	17. Address of hospital	18. Signature of hospital
19. Name of cemetery	20. Address of cemetery	21. Signature of cemetery

22. Name of coroner	23. Address of coroner	24. Signature of coroner
25. Name of registrar	26. Address of registrar	27. Signature of registrar

28. Name of physician	29. Address of physician	30. Signature of physician
31. Name of funeral home	32. Address of funeral home	33. Signature of funeral home

BUREAU V. S.

62 14 1956

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02315

## 2309 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		STATE <b>MARYLAND</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place) <b>1 WEEK</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Peninsula Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>John B. Parsons Home</b>			
<b>3. NAME OF DECEASED</b> (First) <b>HALLIE</b> (Middle) <b>SCARBOROUGH</b> (Last) <b>RORWALLIUS</b>				<b>4. DATE OF DEATH</b> (Month) <b>2</b> (Day) <b>12</b> (Year) <b>19 56</b>			
<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, OR SEPARATED</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>June 14, 1878</b>		<b>9. AGE last birthday</b> <b>77</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10. USUAL OCCUPATION</b> (Give kind of work or business during life, even if retired) <b>Rooming house</b>		<b>105. KIND OF BUSINESS OR INDUSTRY</b> <b>manager</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Peter W. Scarborough</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Emma Taylor</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Lena S. Townsend</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <b>Coronary Occlusion</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>Oct 21, 1955</b> , to <b>2/12, 1956</b> , that I last saw the deceased alive on <b>2/12, 1956</b> , and that death occurred at <b>4:00 P.M.</b> from the causes and on the date stated above.							
<b>SIGNATURE</b> <b>L. K. Grange</b>		<b>M.D.</b> <b>Salisbury Md</b>		<b>ADDRESS</b> (Street, city, town, state) <b>213/54</b>		<b>DATE SIGNED</b> <b>2/13/56</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>2/15/56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Spring Hill Cemetery</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Girdletree Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary H. Holloway</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The Hill &amp; Johnson Co.</b>		<b>ADDRESS</b> <b>Salisbury</b>	

Franklin D. Hill Jr.

CERTIFICATE OF DEATH

NAME OF DECEASED John A. Parsons		RESIDENCE Baltimore, Md.		DATE OF DEATH June 14, 1956		PLACE OF DEATH Home	
AGE 68		SEX Male		RACE White		EDUCATION High School	
OCCUPATION Retired		MARRIAGE Married		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	

BUREAU V. S.

FEB 15 1956

RECEIVED

The Hall & Johnson Co.  
Baltimore, Md.

2310

## CERTIFICATE OF DEATH

Dr. Gilmore &amp; Ellis

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Gen. Hospital</b>				STREET ADDRESS <b>R.D. # 3 (Delmar Road)</b>		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>MARY</b>		(Middle) <b>CATHERINE</b>		(Last) <b>SHOCKLEY</b>		(Month) (Day) (Year) <b>Feb. 10th 19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>JAN. 22, 1896</b>		9. AGE last birthday <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <b>0 19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at own home</b>		11. BIRTHPLACE (State or foreign country) <b>Saluda Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Thomas F. Moore</b>				14. MOTHER'S MAIDEN NAME <b>Virginia Wilkerson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mr. William Harry Shockley (Husband) R.D. # 3 (Delmar Road) Salisbury, Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <b>Cerebral Hemorrhage</b>						<b>1 day</b>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Feb. 10, 1956</b> to <b>Feb. 10, 1956</b> that I last saw the deceased alive on <b>Feb. 10, 1956</b> , and that death occurred at <b>12:05A</b> , from the causes and on the date stated above.							
SIGNATURE <b>Dr. Gilmore</b>				ADDRESS (Street, city, town, state) <b>M.D. Medical Center-Salisbury, Maryland</b>		DATE SIGNED <b>Feb. 13 / 56</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Feb. 14, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. REC'D BY REGISTRAR <b>FEB 15 1956</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1956

# CERTIFICATE OF DEATH

1. DISPOSED OF BY

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SIGNATURE OF DECEASED

8. SIGNATURE OF WITNESSES

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

1956

*Charles H. Hunsicker*

BUREAU V. 3.

FEB 15 1956

RECEIVED

*Feb 10 20 1956*

*[Signature]*

1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2311

## CERTIFICATE OF DEATH

02317

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>SOMERSET</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SALISBURY</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MANOKIN</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Elizabeth</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>February 11 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>Jan. 4, 1915</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundress</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Raleigh, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Emmit Cotton</u>				14. MOTHER'S MAIDEN NAME <u>Lula Guess</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>244-07-6776</u>		17. INFORMANT & ADDRESS <u>Mrs. Lula Cotton - Manokin, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
216X IMMEDIATE CAUSE (A) <u>Pulmonary Embolism</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 Hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Thrombosis of Ovarian Veins</u>						<u>24 "</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Infarction from Thrombosis of Testicular Veins</u>						<u>7 days</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Uterine Fibroids</u>							
19a. DATE OF OPERATION <u>Feb 7, 1956</u>		19b. MAJOR FINDINGS OF OPERATION <u>Absent</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>2-1</u> , 19 <u>56</u> , to <u>2-11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-11</u> , 19 <u>56</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John M. Blofen III</u>				ADDRESS (Street, city, town, state) <u>M.D. Medical Center - Salisbury, Md.</u>		DATE SIGNED <u>2-12-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/16/56</u>		NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		LOCATION (City, town, or county) (State) <u>Manokin, Md.</u>	
24. REC'D. BY REGISTRAR <u>FEB 16 1956</u>		REGISTRAR'S SIGNATURE <u>Mary Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward - Marion Sta., Md.</u>		ADDRESS	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

2112

Reg. Dist. No.

A. PLACE WHERE DEATH OCCURRED

B. PLACE OF BIRTH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. CAUSE OF DEATH

7. PLACE OF BIRTH

8. OCCUPATION

9. MARITAL STATUS

10. EDUCATION

11. RACE

12. COLOR

13. RELIGION

14. USUAL RESIDENCE

15. PLACE OF DEATH

16. PLACE OF BURIAL

17. NAME OF FUNERAL HOME

18. NAME OF MINISTER

19. NAME OF CLERGYMAN

20. NAME OF CHURCH

21. NAME OF CEMETERY

22. NAME OF INTERVIEWER

23. NAME OF REGISTRAR

24. NAME OF CLERK

25. NAME OF ASSISTANT CLERK

26. NAME OF DEPUTY REGISTRAR

27. NAME OF DEPUTY CLERK

28. NAME OF DEPUTY ASSISTANT CLERK

RECEIVED

BUREAU V. 2

FEB 16 1956

RECEIVED

John Wesley

Marshall

Charles F. 2nd - Western St.

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02318

2312

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>6 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>212 Catherine Street</u>			
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(First) <u>Helen</u>		(Middle) <u>Ann</u>		(Last) <u>Slemons</u>		(Month) (Day) (Year) <u>Feb. 7 1956</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>12/29/1871</u>	<b>9. AGE last birthday</b> <u>84</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Housework</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>? Alexander Cottman</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>?</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Unk.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>-</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>420.0 IMMEDIATE CAUSE (A)</b> <u>Arteriosclerotic Heart disease</u>						<u>?</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Arteriosclerosis, general</u>						<u>?</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Chronic brain syndrome due to arteriosclerosis</u>						<u>?</u>	
<b>19a. DATE OF OPERATION</b> <u>-</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>-</u>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<u>-</u>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) <u>-</u>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <u>-</u>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Aug. 2</u> , 19 <u>55</u> , to <u>Feb. 7</u> , 1956, that I last saw the deceased alive on <u>Feb. 7</u> , 19 <u>56</u> , and that death occurred at <u>7:15AM</u> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>V. Juerman</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Deer's Head Hospital, Salisbury, Md.</u>		<b>DATE SIGNED</b> <u>2/7/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>2-12-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Houston Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Salisbury, Wicomico Co. Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>FEB 10 1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary H. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Mary A. Stewart</u>		<b>ADDRESS</b> <u>F. F. Stewart Funeral Home, Salisbury, Md.</u>	

# CERTIFICATE OF DEATH

File No. 12345

1. NAME OF DECEASED JOHN DOE		2. SEX Male		3. AGE 45	
4. DATE OF BIRTH 1910-01-15		5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. RACE White	
7. OCCUPATION Teacher		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural	
10. DATE OF DEATH 1956-02-10		11. PLACE OF DEATH Home		12. SIGNATURE OF PHYSICIAN [Signature]	
13. SIGNATURE OF REGISTRAR [Signature]		14. SIGNATURE OF WITNESS [Signature]		15. SIGNATURE OF DECEASED [Signature]	

BUREAU V. S.

FEB 10 1956

RECEIVED

2313

## CERTIFICATE OF DEATH

02319

Reg. Dist. No. 332

## INSTRUCTIONS

1  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u> COUNTY <u>Sussex</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>3 Days</u>		TOWN <u>LAUREL (RD)</u>		<u>46 x 3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>LAUREL-DeLAC Highway</u>			
3. NAME OF DECEASED (Type or Print) <u>William E. Smith</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>February 25-1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Oct. 12, 1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Store</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George R. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Theodosia Marvel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>221-14-1619</u>		17. INFORMANT & ADDRESS <u>Frank E. Smith Laurel Del.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
540.1 IMMEDIATE CAUSE (A) <u>Perforated peptic ulcer &amp; peritonitis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic c-v disease &amp; decompensation</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						<u>48 hrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-22-1956</u> , to <u>2-25-1956</u> that I last saw the deceased alive on <u>2-25-1956</u> , and that death occurred at <u>Laurel, Del.</u> from the causes and on the date stated above.							
SIGNATURE <u>William H. Fisher Jr.</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/28/56</u>		NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cem.</u>		LOCATION (City, town, or county) (State) <u>Laurel, Del.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Harvey Williamson</u>		ADDRESS <u>Laurel, Del.</u>	
DATE <u>FEB 27 1956</u>							

# CERTIFICATE OF DEATH

2513

1. DECEASED'S NAME (PRINT OR TYPE)

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MEDICAL OPINION

8. SIGNATURE

BUREAU V. 8

FEB 28 1956

RECEIVED

MASSACHUSETTS

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1

INSTRUCTIONS

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

02320

Reg. Dist. No. ....

2314

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		COUNTY <u>Worcester</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS <u>238-2</u>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>William T. Smith</u>				<b>4. DATE OF DEATH</b> (Month) <u>February</u> (Day) <u>9</u> (Year) <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>A.A.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>12-25-1895</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER YARD</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN, WORCESTER CO., MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN SMITH</u>				14. MOTHER'S MAIDEN NAME <u>LIZZIE DENNIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u>		16. SOCIAL SECURITY NO. <u>213-55-0781</u>		17. INFORMANT & ADDRESS <u>MRS. SUSIE J. SMITH, BERLIN, MD.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
442x IMMEDIATE CAUSE (A) <u>CEREBRO VASCULAR ACCIDENT</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIO SCLEROTIC HYPERTENNE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>CARDIO VASCULAR RENAL</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>DISEASE</u>				<u>Years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>2/6/56</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/6/56</u> , to <u>2/9/56</u> , that I last saw the deceased alive on <u>2/8/56</u> , and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-12-56</u>		NAME OF CEMETERY OR CREMATORY <u>EMERALD GREEN CEMETERY</u>		LOCATION (City, town, or county) (State) <u>BERLIN, WORCESTER CO., MD</u>	
24. REC'D BY REGISTRAR <u>Mary H. Hollaway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary A. Stewart</u>		ADDRESS <u>Stewart Funeral Home, Salisbury, Md.</u>	
DATE <u>FEB 14 1956</u>							

# CERTIFICATE OF DEATH

1955

2018

A DEATH CERTIFICATE MUST BE OBTAINED

STATE OF MASSACHUSETTS

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BUREAU V. S.

FEB 14 1955

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02321

2315

## CERTIFICATE OF DEATH

Dr. Burton &amp; Mitchell

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>503 Mitchell St</b>				STREET ADDRESS (If rural give location) <b>503 Mitchell St.</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>PIETRO S. TESTA</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>FEB. 3 rd 19 56</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>Dec. 26, 1866</b>		<b>9. AGE last birthday</b> <b>89</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>1</b> Days <b>7</b>	<b>IF UNDER 24 HRS.</b> Hours <b>7</b> Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Merchant</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Confectionery Store</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Cefalu - Sicily Italy</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>Nunzio Testa</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Santa Culotta</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Unk</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Frances Testa (Wife) 502 Mitchell St. Salisbury, Maryland</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>420.0 IMMEDIATE CAUSE (A)</b> <b>Cardiac arrest.</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Congestive heart failure</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <b>Arteriosclerotic heart disease</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Anemia -</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 1/18/54, to 2/3/56, that I last saw the deceased alive on 2/3/56, and that death occurred at 6:35P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>A. C. Mitchell</b>				<b>ADDRESS (Street, city, town, state)</b> <b>M.D. Maryland Ave. Salisbury, Maryland Feb. 6/1956</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Feb 6, 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Wicomico Memorial Park</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Salisbury, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mary H. Holloway</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY</b>			
<b>DATE</b> <b>FEB 7 1956</b>				<b>ADDRESS</b> <b>SALISBURY MARYLAND</b>			

# CERTIFICATE OF DEATH

2332

BALTIMORE STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

*Cardiac arrest  
congestive heart failure  
arteriosclerotic heart disease  
- chronic*

**RECEIVED**  
FEB 7 1956  
BUREAU V. 3

118 24 2/3

cc. C. Jackson  
2/3 25

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02322

2316

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>MARDELLA</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>ROUTE 1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>TENNESSEE</u> (First) <u>THOMAS</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <u>FEB.</u> (Day) <u>15</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>M.</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. SINGLE</b> <input checked="" type="checkbox"/> <b>MARRIED</b> <input type="checkbox"/> <b>WIDOWED, DIVORCED,</b> (Specify)	<b>8. DATE OF BIRTH</b> <u>AUGUST 26, 1930</u>		<b>9. AGE last birthday</b> <u>75</u> yrs.	<b>IF UNDER 1 YEAR</b> (Months) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>MILLER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>MILLING BUSINESS</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>ALBERT THOMAS</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>WILHELMINA COOPER</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>YES</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>MRS. THOMAS MCCREA-FEDERALSBURG</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Myocardial Infarct, acute</u>				INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... M., from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>William R. Ellis, Jr. M.D.</u>				<b>DATE SIGNED</b> <u>2-17-56</u>			
<b>23. ADDRESS</b> (Street, city, town, state) <u>Federalburg Md.</u>							
<b>24. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b> <u>4/19/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>CONCORD CEMETERY</u>		<b>LOCATION</b> (City, town, or county) (State) <u>FEDERALSBURG - RFD.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary W. Holloman</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Harvey Williams - Federalburg Md.</u>		<b>ADDRESS</b>	
<b>DATE</b> <u>2-21-56</u>							

# CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - ALBANY, N.Y.

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. DATE OF BIRTH

7. NAME OF DECEASED

8. NAME OF NEXT OF KIN

9. NAME OF PHYSICIAN

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. NAME OF DECEASED (if different from 7)

BUREAU V. S.

FEB 23 1956

RECEIVED

u/1d/20 Concord Cemetery

## INSTRUCTIONS

VS A15C 1-55 10M

# DEATH CERTIFICATE

Form 100-100

1. NAME OF DECEASED

2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH

6. OCCUPATION

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. PLACE OF DEATH

12. SEX

13. AGE

14. DATE OF BIRTH

15. PLACE OF BIRTH

16. OCCUPATION

17. CAUSE OF DEATH

18. DATE OF DEATH

19. TIME OF DEATH

20. PLACE OF DEATH

21. SEX

22. AGE

23. DATE OF BIRTH

24. PLACE OF BIRTH

25. OCCUPATION

26. CAUSE OF DEATH

27. DATE OF DEATH

28. TIME OF DEATH

29. PLACE OF DEATH

30. SEX

31. AGE

32. DATE OF BIRTH

33. PLACE OF BIRTH

34. OCCUPATION

35. CAUSE OF DEATH

36. DATE OF DEATH

37. TIME OF DEATH

38. PLACE OF DEATH

39. SEX

40. AGE

41. DATE OF BIRTH

42. PLACE OF BIRTH

43. OCCUPATION

44. CAUSE OF DEATH

45. DATE OF DEATH

46. TIME OF DEATH

47. PLACE OF DEATH

48. SEX

49. AGE

50. DATE OF BIRTH

51. PLACE OF BIRTH

52. OCCUPATION

53. CAUSE OF DEATH

54. DATE OF DEATH

55. TIME OF DEATH

56. PLACE OF DEATH

57. SEX

58. AGE

59. DATE OF BIRTH

60. PLACE OF BIRTH

61. OCCUPATION

62. CAUSE OF DEATH

63. DATE OF DEATH

64. TIME OF DEATH

65. PLACE OF DEATH

66. SEX

67. AGE

68. DATE OF BIRTH

69. PLACE OF BIRTH

70. OCCUPATION

71. CAUSE OF DEATH

72. DATE OF DEATH

73. TIME OF DEATH

74. PLACE OF DEATH

75. SEX

76. AGE

77. DATE OF BIRTH

78. PLACE OF BIRTH

79. OCCUPATION

80. CAUSE OF DEATH

81. DATE OF DEATH

82. TIME OF DEATH

83. PLACE OF DEATH

84. SEX

85. AGE

86. DATE OF BIRTH

87. PLACE OF BIRTH

88. OCCUPATION

89. CAUSE OF DEATH

90. DATE OF DEATH

91. TIME OF DEATH

92. PLACE OF DEATH

93. SEX

94. AGE

95. DATE OF BIRTH

96. PLACE OF BIRTH

97. OCCUPATION

98. CAUSE OF DEATH

99. DATE OF DEATH

100. TIME OF DEATH

101. PLACE OF DEATH

102. SEX

103. AGE

104. DATE OF BIRTH

105. PLACE OF BIRTH

106. OCCUPATION

107. CAUSE OF DEATH

108. DATE OF DEATH

109. TIME OF DEATH

110. PLACE OF DEATH

111. SEX

112. AGE

113. DATE OF BIRTH

114. PLACE OF BIRTH

115. OCCUPATION

116. CAUSE OF DEATH

117. DATE OF DEATH

118. TIME OF DEATH

119. PLACE OF DEATH

120. SEX

121. AGE

122. DATE OF BIRTH

123. PLACE OF BIRTH

124. OCCUPATION

125. CAUSE OF DEATH

126. DATE OF DEATH

127. TIME OF DEATH

128. PLACE OF DEATH

129. SEX

130. AGE

131. DATE OF BIRTH

132. PLACE OF BIRTH

133. OCCUPATION

134. CAUSE OF DEATH

135. DATE OF DEATH

136. TIME OF DEATH

137. PLACE OF DEATH

138. SEX

139. AGE

140. DATE OF BIRTH

141. PLACE OF BIRTH

142. OCCUPATION

143. CAUSE OF DEATH

144. DATE OF DEATH

145. TIME OF DEATH

146. PLACE OF DEATH

147. SEX

148. AGE

149. DATE OF BIRTH

150. PLACE OF BIRTH

151. OCCUPATION

152. CAUSE OF DEATH

153. DATE OF DEATH

154. TIME OF DEATH

155. PLACE OF DEATH

156. SEX

157. AGE

158. DATE OF BIRTH

159. PLACE OF BIRTH

160. OCCUPATION

161. CAUSE OF DEATH

162. DATE OF DEATH

163. TIME OF DEATH

164. PLACE OF DEATH

165. SEX

166. AGE

167. DATE OF BIRTH

168. PLACE OF BIRTH

169. OCCUPATION

170. CAUSE OF DEATH

171. DATE OF DEATH

172. TIME OF DEATH

173. PLACE OF DEATH

174. SEX

175. AGE

176. DATE OF BIRTH

177. PLACE OF BIRTH

178. OCCUPATION

179. CAUSE OF DEATH

180. DATE OF DEATH

181. TIME OF DEATH

182. PLACE OF DEATH

183. SEX

184. AGE

185. DATE OF BIRTH

186. PLACE OF BIRTH

187. OCCUPATION

188. CAUSE OF DEATH

189. DATE OF DEATH

190. TIME OF DEATH

191. PLACE OF DEATH

192. SEX

193. AGE

194. DATE OF BIRTH

195. PLACE OF BIRTH

196. OCCUPATION

197. CAUSE OF DEATH

198. DATE OF DEATH

199. TIME OF DEATH

200. PLACE OF DEATH

201. SEX

202. AGE

203. DATE OF BIRTH

204. PLACE OF BIRTH

205. OCCUPATION

206. CAUSE OF DEATH

207. DATE OF DEATH

208. TIME OF DEATH

209. PLACE OF DEATH

210. SEX

211. AGE

212. DATE OF BIRTH

213. PLACE OF BIRTH

214. OCCUPATION

215. CAUSE OF DEATH

216. DATE OF DEATH

217. TIME OF DEATH

218. PLACE OF DEATH

219. SEX

220. AGE

221. DATE OF BIRTH

222. PLACE OF BIRTH

223. OCCUPATION

224. CAUSE OF DEATH

225. DATE OF DEATH

226. TIME OF DEATH

227. PLACE OF DEATH

228. SEX

229. AGE

230. DATE OF BIRTH

231. PLACE OF BIRTH

232. OCCUPATION

233. CAUSE OF DEATH

234. DATE OF DEATH

235. TIME OF DEATH

236. PLACE OF DEATH

237. SEX

238. AGE

239. DATE OF BIRTH

240. PLACE OF BIRTH

241. OCCUPATION

242. CAUSE OF DEATH

243. DATE OF DEATH

244. TIME OF DEATH

245. PLACE OF DEATH

246. SEX

247. AGE

248. DATE OF BIRTH

249. PLACE OF BIRTH

250. OCCUPATION

251. CAUSE OF DEATH

252. DATE OF DEATH

253. TIME OF DEATH

254. PLACE OF DEATH

255. SEX

256. AGE

257. DATE OF BIRTH

258. PLACE OF BIRTH

259. OCCUPATION

260. CAUSE OF DEATH

261. DATE OF DEATH

262. TIME OF DEATH

263. PLACE OF DEATH

264. SEX

265. AGE

266. DATE OF BIRTH

267. PLACE OF BIRTH

268. OCCUPATION

269. CAUSE OF DEATH

270. DATE OF DEATH

271. TIME OF DEATH

272. PLACE OF DEATH

273. SEX

274. AGE

275. DATE OF BIRTH

276. PLACE OF BIRTH

277. OCCUPATION

278. CAUSE OF DEATH

279. DATE OF DEATH

280. TIME OF DEATH

281. PLACE OF DEATH

282. SEX

283. AGE

284. DATE OF BIRTH

285. PLACE OF BIRTH

286. OCCUPATION

287. CAUSE OF DEATH

288. DATE OF DEATH

289. TIME OF DEATH

290. PLACE OF DEATH

291. SEX

292. AGE

293. DATE OF BIRTH

294. PLACE OF BIRTH

295. OCCUPATION

296. CAUSE OF DEATH

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02324

2318

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>12 SALISBURY</u>				TOWN <u>12 SALISBURY</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>7 FILMORE STREET</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Bessie M. Tingle</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>February 4<sup>th</sup> 1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Sept. 28, 1886</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jessie Evans</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Mrs. Wm. Allen - Salisbury, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>							
ANTECEDENT CAUSE(S) DUE TO <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Arteriosclerosis</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 3rd, 1956</u> to <u>Feb 4th, 1956</u> that I last saw the deceased alive on <u>Feb 4th, 1956</u> , and that death occurred at <u>6:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Carrie D. Hearn</u>		M.D. <u>236 N. Riverside Dr</u>		DATE SIGNED <u>2/6/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2/7/56</u>		NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Wells - Md. R.D.</u>	
24. REC'D BY REGISTRAR <u>2-9-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Howard Wells - Pittsview</u>		ADDRESS <u>not</u>	

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

## CERTIFICATE OF DEATH

Form No. 100

1. NAME OF DECEASED

2. SEX

3. PLACE OF DEATH

4. OCCUPATION

5. MARITAL STATUS

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. DATE OF DEATH

9. TIME OF DEATH

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF CORONER

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF CLERK

17. SIGNATURE OF JURY

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF DEPUTY SHERIFF

21. SIGNATURE OF CONSTABLE

22. SIGNATURE OF ALDERMAN

23. SIGNATURE OF COUNCILMAN

24. SIGNATURE OF CLERK OF THE COURT

25. SIGNATURE OF JURY

26. SIGNATURE OF JUDGE

27. SIGNATURE OF SHERIFF

28. SIGNATURE OF DEPUTY SHERIFF

29. SIGNATURE OF CONSTABLE

30. SIGNATURE OF ALDERMAN

31. SIGNATURE OF COUNCILMAN

32. SIGNATURE OF CLERK OF THE COURT

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34. SIGNATURE OF JUDGE

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39. SIGNATURE OF COUNCILMAN

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42. SIGNATURE OF JUDGE

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105. SIGNATURE OF JUDGE

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110. SIGNATURE OF COUNCILMAN

111. SIGNATURE OF CLERK OF THE COURT

112. SIGNATURE OF JURY

113. SIGNATURE OF JUDGE

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248. SIGNATURE OF JURY

249. SIGNATURE OF JUDGE

250. SIGNATURE OF SHERIFF

251. SIGNATURE OF DEPUTY SHERIFF

252. SIGNATURE OF CONSTABLE

253. SIGNATURE OF ALDERMAN

254. SIGNATURE OF COUNCILMAN

Dr. Insley

2319

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Spring Hill Private Sanitarium</b> OR INSTITUTION <b>In Nursing Home</b>				d. STREET ADDRESS <b>704 Goldsborough St</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ALICE</b> Last <b>TODD</b>				4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 30, 1884</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Dames Quarter Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - House Work at Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Dames Quarter Maryland</b>			
13. FATHER'S NAME <b>William Alexander Shores</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Alice Carew</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mr. Samuel J.E. Todd (Son)</b>				Address <b>704 Goldsborough St Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular renal disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 20, 1956</b> to <b>Feb. 20, 1956</b> , that I last saw the deceased alive on <b>February 20, 1956</b> , and that death occurred at <b>4:20 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip A. Insley</b>				ADDRESS (Street, city or town, state) <b>E. Main St</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Philip A. Insley</b>				DATE SIGNED <b>Feb. 21 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 22, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Chance, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>FEB 23 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 23 1956

BUREAU V. S.

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. PLACE OF DEATH	
9. TIME OF DEATH	
10. SIGNATURE OF PHYSICIAN	
11. SIGNATURE OF REGISTRAR	
12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED	
14. SIGNATURE OF NEXT OF KIN	
15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME	
17. SIGNATURE OF CEMETERY	
18. SIGNATURE OF CHURCH	
19. SIGNATURE OF MINISTERS	
20. SIGNATURE OF OTHERS	

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02326

## 2320 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL or end, give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>3 weeks</u>		TOWN <u>Pocomoke</u>		<u>23X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>R. F. D #3.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>George</u> (First) <u>Ward</u> (Middle) <u>Ward</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>February</u> (Day) <u>22</u> (Year) <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Feb 18-1872</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COWN</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS W. WARD</u>				14. MOTHER'S MAIDEN NAME <u>SALLIE E. ROBERTSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>                    </u>		17. INFORMANT & ADDRESS <u>MRS BESSIE E. WARD</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		INTERVAL BETWEEN ONSET AND DEATH	
610X IMMEDIATE CAUSE (A) <u>Brunn Prostatic Hypertrophy</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Generalized atherosclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>2-7</u> , 19 <u>56</u> , to <u>2-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-22</u> , 19 <u>56</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>H. Brulte</u>		M.D. <u>Medical Center</u>		ADDRESS (Street, city, town, state) <u>2122 56</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>FEB 25-1956</u>		NAME OF CEMETERY OR CREMATORY <u>BETHEDEN CEMETERY</u>		LOCATION (City, town, or county) (State) <u>Rural Pocomoke Md.</u>	
24. REC'D BY REGISTRAR <u>FEB 27 1956</u>		REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry D. Watson</u>		ADDRESS <u>(Pocomoke)</u>	

# CERTIFICATE OF DEATH

Death Date 1956

1. GROUP A - PROBABLE CAUSE OF DEATH

MARYLAND

DECEASED

25017041701

BUREAU V. S.

FEB 27 1956

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02327

## 2336 CERTIFICATE OF DEATH

Item 9, FilmGL93 2-27-56 et

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>St Michaels</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>St Michaels</u> STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) <u>Edith</u> (Middle) <u>J.</u> (Last) <u>Waters</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>2</u> <u>9</u> 19 <u>56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5-10-84</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>China</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Robert Wainwright</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Conway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Arthur Waters</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.0</u> IMMEDIATE CAUSE (A) <u>Acute Coronary Failure</u>				<u>1 hour</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery Heart Disease</u>				<u>10 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pneumonia</u>				<u>1 week</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White et work <input type="checkbox"/> Not white et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/15</u> , 19 <u>49</u> , to <u>2/9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/9</u> , 19 <u>56</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Richard H. Sanderson</u> M.D.				DATE SIGNED <u>2/10/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-12-56</u>		NAME OF CEMETERY OR CREMATORY <u>Newtown Cem</u>		LOCATION (City, town, or county) (State) <u>Newtown MD</u>	
24. REC'D BY REGISTRAR DATE <u>2-16-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. Crest</u>			

# CERTIFICATE OF DEATH

Form 10-1-1956

1. NAME OF DECEASED

MARYLAND

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. PLACE OF BIRTH

6. AGE AT DEATH

7. SEX

8. RACE

9. OCCUPATION

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF CLERGYMAN

18. SIGNATURE OF BURIAL OFFICIAL

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF CEMETERY

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

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60. SIGNATURE OF INTERVIEWER

BUREAU V. 2

FEB 20 1956

RECEIVED

PHOTODUPLICATION

This is a true and correct copy of the original as filed in the files of the Maryland State Department of Health, Baltimore, Maryland, on the 20th day of February, 1956.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02328

2321

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>1 yr 2½ mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton</u>		<u>2040-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>Court Street</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>HARRY</u> <u>EDWARD</u> <u>WILHELM</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>February 6, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 28, 1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll County, Md., USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Wilhelm</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
416X IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Rheumatic heart disease</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis</u>						?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>Nov. 12, 1954</u> , to <u>Feb. 6, 1956</u> , that I last saw the deceased alive on <u>Feb. 6, 1956</u> , and that death occurred at <u>12:50 P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>Dr. J. Guerman</u> M.D. <u>Deer's Head State Hosp., Salisbury</u> Md. DATE SIGNED <u>2/6/56</u> ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-10-56</u>		NAME OF CEMETERY OR CREMATORY <u>HAMPSTEAD CEMETERY</u>		LOCATION (City, town, or county) (State) <u>HAMPSTEAD, MARYLAND</u>	
24. REC'D BY REGISTRAR <u>Mary M. Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Thompson</u>		ADDRESS <u>Easton, Md.</u>	
DATE <u>FEB 14 1956</u>							

# CERTIFICATE OF DEATH

3993

Nov. 1951, No.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF TOWN CLERK

21. SIGNATURE OF TOWN ENGINEER

22. SIGNATURE OF TOWN CHURCH

23. SIGNATURE OF TOWN SCHOOL

24. SIGNATURE OF TOWN LIBRARY

25. SIGNATURE OF TOWN OFFICE

26. SIGNATURE OF TOWN CHURCH

27. SIGNATURE OF TOWN SCHOOL

28. SIGNATURE OF TOWN LIBRARY

29. SIGNATURE OF TOWN OFFICE

30. SIGNATURE OF TOWN CHURCH

31. SIGNATURE OF TOWN SCHOOL

32. SIGNATURE OF TOWN LIBRARY

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43. SIGNATURE OF TOWN SCHOOL

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46. SIGNATURE OF TOWN CHURCH

47. SIGNATURE OF TOWN SCHOOL

48. SIGNATURE OF TOWN LIBRARY

49. SIGNATURE OF TOWN OFFICE

50. SIGNATURE OF TOWN CHURCH

BUREAU V. S.

RECEIVED

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 12

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02329

2322

# CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Salisbury</u>		<u>8 months</u>		TOWN <u>Salisbury</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>Jersey Road - Route # 2</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>George Willing</u>				<u>Feb. 17 1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>1/20/1885</u>	<u>71</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Farmer</u>		<u>Farming</u>		<u>Maryland</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>James Willing</u>				<u>Annie Darr</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>Unk.</u>				<u>Mrs. Rose Willing (Wife) Salisbury, Maryland and Hospital Records (R.D. #2)</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <u>Myocardial insufficiency</u>						<u>36 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<u>5 yrs</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>		<b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>6/23</u> , 19 <u>55</u> , to <u>2/17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/17</u> , 19 <u>56</u> , and that death occurred at <u>4:10 P.M.</u> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>L. V. Maldve, M.D.</u>				<b>DATE SIGNED</b> <u>2/17/56</u>			
<b>ADDRESS</b> (Street, city, town, state)				<b>DATE SIGNED</b>			
<u>M.D. Deer's Head Hospital; Salisbury, Md.</u>				<u>2/17/56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>Feb. 19, 1956</u>		<u>Parsons Cemetery</u>		<u>Salisbury, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>FEB 20 1956</u>		<u>Mary H. Holloway</u>		<u>HOLLOWAY &amp; COMPANY</u>		<u>SALISBURY MARYLAND</u>	

BUREAU V. S.

FEB 20 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02330

2337 **CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mardela</u>		LENGTH OF STAY (in this place) <u>77 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mardela</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route # 50</u>				STREET ADDRESS (If rural give location) <u>Route # 50</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) <u>Lena</u> (Middle) <u>Ellen</u> (Last) <u>Wilson</u>				<b>4. DATE OF DEATH</b> (Month) <u>Feb.</u> (Day) <u>3,</u> (Year) <u>19 56</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>June 5, 1878</u>		<b>9. AGE last birthday</b> <u>77</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>At Home</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Wicomico County, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Benjamin H. Graham</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Virginia C. Hurley</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>213-16-7474</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Louis H. Wilson, Mardela, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>1. IMMEDIATE CAUSE (A)</b> <u>420.1</u> <u>coronary occlusion</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1/2 hour</u>	
<b>2. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (B) <u>coronary arteriosclerosis</u>						<u>?</u>	
<b>(C)</b> <u>generalized arteriosclerosis</u>						<u>?</u>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>obesity</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>19 50</u> , to <u>Feb 3, 19 56</u> , that I last saw the deceased alive on <u>Jan 56</u> , and that death occurred at <u>12 29</u> AM, from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>[Signature]</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Belmar Md.</u>		<b>DATE SIGNED</b> <u>2-6-56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>2-6-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Mardela</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Mardela, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>FEB 9 1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u> ADDRESS			



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2323

## CERTIFICATE OF DEATH

Reg. Dist. No. 02331 35 ✓ 476

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>SALISBURY</u>		LENGTH OF STAY (in this place) <u>11 DAYS</u>		TOWN <u>Beaufort, N.C.</u>		TOWN <u>Beaufort, N.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>Rural</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>ARTHUR TUTTLE WOODLAND</u>				<u>FEB. 19 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>1/22/1878</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea food</u>		11. BIRTHPLACE (State or foreign country) <u>Beaufort, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Handman</u>				14. MOTHER'S MAIDEN NAME <u>Luanna Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Ms. Betty Ann Beaufort, N.C.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>19. MEDICAL CERTIFICATION</b>			
422.1 IMMEDIATE CAUSE (A) <u>Cardiorenal C. V. Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>yes</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>with gangrene of feet</u>				<u>10 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH?</b>							
19a. DATE OF OPERATION <u>2-10-56</u>		19b. MAJOR FINDINGS OF OPERATION <u>Gangrene of feet</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-8</u> , 19 <u>56</u> , to <u>2-19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-19</u> , 19 <u>56</u> , and that death occurred at <u>6:19</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>H. Brille</u>		M.D. <u>Medical Center</u>		ADDRESS (Street, city, town, state) <u>Beaufort, N.C.</u>		DATE SIGNED <u>2-19-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2/21/56</u>		NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		LOCATION (City, town, or county) (State) <u>Beaufort, N.C.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Beaufort, N.C.</u>		ADDRESS	
DATE <u>Feb. 30, 1956</u>							

RECEIVED

FEB 21 1956

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Reg. Dist. No.

2. NAME EXCLUDING NICKNAME OR AKA

DATE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Place of Death

Time of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Nurse

Signature of Chaplain

Signature of Minister

Signature of Priest

Signature of Rabbi

Signature of Imam

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

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Signature of Other

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02332

2324

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>5 years</u>		TOWN <u>Salisbury</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Katie</u> <u>Wright</u>				<u>Feb.</u> <u>2</u> <u>19 56</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Female</u>	<u>Colored</u>	<u>Widowed</u>	<u>4/17/1873</u>	<u>82</u>	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Housewife</u>		<u>Housework</u>		<u>Oklahoma</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Dave Blackbird</u>				<u>Melissa Ross</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>-</u>		<u>Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>332X</u> IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						<u>16 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, general</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<u>?</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>		<b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
<u>-</u>		<u>-</u>		<u>-</u>		<u>-</u>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<u>-</u>		<u>-</u>		<u>-</u>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<u>-</u>		<u>M.</u>		<u>-</u>			
<b>22. I hereby certify</b> that I attended the deceased from <u>Mar. 1</u> , 19 <u>51</u> , to <u>Feb. 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 2</u> , 19 <u>56</u> , and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Dr. Juerman</u> <u>V. Juerman, M.D.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Deer's Head Hospital, Salisbury, Md.</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>DATE SIGNED</b> <u>2/3/56</u>			
<u>BURIAL</u>		DATE THEREOF <u>2/7/56</u>		NAME OF CEMETERY OR CREMATORY <u>W. &amp; Med. School</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
<b>24. RECD BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>FEB 15 1956</u>		<u>Mary H. Holloway</u>		<u>[Signature]</u>		<u>[Address]</u>	

# CERTIFICATE OF DEATH

LOCAL HEALTH OFFICE IN WHICH DECEASED RESIDED

DECEASED'S NAME

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

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DATE OF RECREMATION

PLACE OF RECREMATION

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DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

BUREAU V. S.

FEB 16 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2325

## CERTIFICATE OF DEATH

02333

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place)		OR TOWN <u>Salisbury</u>		OR TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>307 Washington Street</u>				STREET ADDRESS (If rural give location) <u>307 Washington Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Ida</u> (Middle) <u>Bozman</u> (Last) <u>Young</u>				<u>Feb.</u> <u>14</u> <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>July 18, 1880</u>	<u>75</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>at home</u>		<u>at home</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Bozman</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>no</u>		<u>307 Washington Street</u> <u>L.D. Young Salisbury, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>260x Diabetic coma + gangrene</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerosis generalized</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cerebral hemorrhage</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>no</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug</u> , 19 <u>55</u> , to <u>Feb 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 17</u> , 19 <u>56</u> , and that death occurred at <u>4 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Alberto Mattar</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md</u> DATE SIGNED <u>2/15/1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/19/1956</u>		<u>Wicomico Mem. Park</u>		<u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>FEB 17 1956</u>		<u>Mary H. Holloway</u>		<u>Thomas F. Wallace, Salisbury, Md.</u>		<u>Salisbury, Md.</u>	

BUREAU V. S.

FEB 17 1956

RECEIVED